



Gandhi Memorial College Of Education, Jammu

Status of Women in India

Sovan Kumar Patnaik



The unique work 'Status of Women in India' presents a comprehensive and detailed account of women in the society with a macro-framework. It analyses the socio-economic demographic problems of women in Indian start up with particular reference to the state of Orissa. The book focuses especially on the problem and status of women's health on the basis of field exploration and undoubtedly, a veritable mine of information to the women activists, students of women studies, planners, sociologists and general readers.

CONTENTS

1. Introduction
2. Status of Women in India
3. Socio-economic Conditions of Women
4. Issues on Women's Health
5. Findings and Conclusions

Bibliography

Rs. 300/-

STATUS OF WOMEN IN INDIA

STATE OF JAMMU AND KASHMIR

STATUS OF WOMEN IN INDIA

G.M. College of Education
Raipur, Bantalab
Jammu
Acc. No. 9584
Dated. 30-3-11

25-II

By
Sovan Kumar Patnaik

G.M.C.E.J



9584



SONALI PUBLICATIONS
NEW DELHI-110002

First Published-2007

ISBN 81-8411-079-0

© Author

Published by

SONALI PUBLICATIONS

4228/1, Ansari Road,

New Delhi-110 002 (India)

Phone: 23266109, 23279245

Fax: 91-11-23253475

E-mail: sonalipub@yahoo.co.in

Printed at:

Sachin Printers, Delhi-

ACKNOWLEDGEMENT

A woman of integrity and a veracious teacher, my guide and mentor, *Professor Snehalata Panda*, Former Director of Women's Studies Research Centre, Berhampur University, is the driving force behind my work. She ensures that every student under her tutelage does the job with commitment and precision.

It is a matter of great honour for me to be a disciple of Professor Snehalata Panda, whose suggestions and encouragement helped me to take up this task successfully. Words will certainly fail to picture the guidance and encouragement provided to me to revise the work by Dr. S.N. Tripathy, Reader in Economics, Aska Science College.

There have been moments, when the flame of my endeavours has flickered like a candle in the wind; and at these moments of human frailty I have received comfort and encouragement to move forward with noble purposes. Everything about my revered father under whose spiritual nourishment, golden touch and protective care I have come up to this level. I am deeply indebted to him for having brought me to this level of enlightenment by giving me right education, valuable advice and throwing the gates of wisdom open for me.

I render my heartiest obligation to Suhrut Bhaina, Assistant Director, International Health Division, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi for providing me a plethora of materials.

I feel highly indebted to Prof. K.N. Padhi, Director of Institute of Economic Studies, is methodical, shipshape and decorous. His wit and knowledge, meticulous plans are infectious. I render my heartfelt gratitude to my beloved teacher, without him this research work could have been impossible.

Last but not the least, I owe my gratitude to Mr. T.R. Wasan for Publishing the work within the record time.

—Sobhan Patnaik

ACKNOWLEDGEMENT

A word of thanks is due to the authorities of the college for providing me with the facilities and the necessary help and support during the course of my study. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support. I am also indebted to the members of the faculty for their valuable suggestions and criticisms. I am also grateful to the friends and relatives for their encouragement and support.

PREFACE

For the last three decades it is heartening to note that various aspects of women in Orissa have attracted the attention of researchers and scholars and considerable literature have been generated. Despite this the health status of women has not yet received the due attention of the scholars working on feminism. This study is an humble and modest attempt to explore the health status of women in Orissa particularly of those living in slums.

The health and nutrition records of women are very much dismal, irrespective of their socio-economic position. Of course, socially and economically well-to-do women can afford heavy medical expenses, but the poor and needy labour class women neither have knowledge and time to keep them healthy nor can they afford expensive treatment. "Their poor health condition accentuated by their seething poverty and low calorie food intake. In this study the scholar has attempted to investigate the reasons for the poor health status of slum women. The method of the study is purely exploratory. The slum area has been chosen for study on account of the familiarity of the researcher, adding to this the appalling health conditions have instilled concern in the scholar. This is what has prompted this scholar to make an empirical study on the health status of women. It is the utter lack of awareness on the part of slum living women which has goaded them into the miserable conditions.

In this study spreading over five chapters, conceptual framework of women's health status has been discussed, the status of women in Orissa has been highlighted. The socio-economic condition of slum women of the area of study have been presented, health and medicare of sample women have been analysed and findings and suggestions are elaborated.

The chapter-wise approach has been reflected in the chapter theme of the introduction. For presenting this study the scholar has visited the concerned slum area on several occasion and met a cross section of women in order to have on the spot knowledge of the maladies afflicting their health status. Unless health conditions improved, nothing can improve.

The interview, personal meet, interface understanding of the problem have helped the scholar to find out the real causes and make his findings and observations. It is hoped that this study may help the social activists, the institutions, organizations and individuals to assess and evaluate the poor health status of women and locate remedies for their alleviation.

—Sobhan Patnaik

CONTENT

Acknowledgement

Preface

1. Introduction	1
2. Status of Women in India	26
3. Socio-Economic Conditions of Women	66
4. Issues on Women's Health	76
5. Findings and Conclusions	94
<i>Bibliography</i>	104

1

INTRODUCTION

An attempt has been made in this chapter to outline the objectives, methodology and present a review of literature on women and their health status.

Health is a multi-dimensional phenomenon. The WHO defines health as “a state of physical, mental and social well-being and not merely the absence of disease or infirmity”. The social, health and nutritional status of the most vulnerable sections of society, namely the women, which is the focus of the study reflects the real index of development of any nation or society. According to the Human Development Index (HDI). India ranks 124th position in the list of nations (*Human Development Report* UNDP, 2002). As far as the women of our country are concerned a multitude of reports point out the continued marginalisation of the ‘better’ half of the society. Women’s health status, in general, is abysmally poor. This is directly related to their low status in society. The Gender Related Development Index (GDI) for India is 103, with a female literacy rate as low as 39 per cent, and much lower in many states. It is reflected in overt statistical trends like falling sex ratio (currently 971 females per 1000 males), and persisting high maternal mortality (estimates ranging from 300 to 900 deaths per 100,000 birth, compared to low two digit figures in the Developed countries). The parameters reflecting women’s health are depressing, for example, inverse sex ratio, maternal mortality etc., which are dealt in the subsequent sections.

CONCEPTUAL FRAMEWORK

As for Orissa, the HDI ranks the State at the 12th position among the 15 major States of the country (*Human Development*

Report, UNDP, 2001). The Maternal Mortality Rate (MMR) on the other hand figures at 367 : 1,00,000 as compared to the National MMR rate of 407 : 1,00,000 in the year 1998 (*Human Development Report*, UNDP, 2002). The relationship between poverty and health or health and development is complex, multi-faceted and multi-directional. Poverty in its worse form—as a state of food deprivation and nutritional deficiency coupled with lack of access to critical basic amenities including safe drinking water, sanitation, health care and education contribute to reinforcing ill health and morbidity leading to higher mortality levels of the mother and the child. The vicious circle of poverty manifest itself the low intake of food and nutrients, under-nutrition, high incidence of nutrition related diseases and stunted development of children, small body size of adults, impaired productivity and low earning capacity.

In fact, women like the poor, have been conditioned to a culture of passive silence, and they need to be put through a process of enabling of empowerment, they could articulate adequately and effectively. And as such, they need to be the focus of special attention—and even exclusive measures—until they could be counted upon to withstand the silencing forces. Women's health, in man's world, doesn't seem to get the attention it deserves. We do seem to need a new slogan: "Women's health in women's hands". When women have space and time to meet, their pains get shared, their concerns get articulated, their goals get classified and their energies get galvanised. And they become a power. It is empowerment that comes from within (Edwin, 1998).

It is recognised that the initiative and efforts taken to address women's issues have been inadequate, distorted, and vertical, top-down and have rarely emerged out of women's priority concerns. Rarely have women's experiences, views, concerns and local health practices received the priority they deserve. For example, the universal package of 'iron folic acid' and tetanus toxoid; have been represented as the only solution for improved maternal health. Women's access to adequate food or caloric deficit, due to her continued hard physical labour till the end of pregnancy, remains a non-issue. Even when it

is women in the reproductive child-bearing age that have received attention, the focus has been on fertility control. The problems of girls, especially adolescents, women who are unmarried, childless, older, disabled, deserted, etc., have been neglected.

The marginalisation of women is worsened when it is associated with poverty, illiteracy, rural background, lower caste, widowhood, desertion, disability, single marital status or childlessness. Women, in our society are spoken of as '*devis*' yet denied of their rights to personhood and discriminated against because of their gender. This phenomenon is worst in the northern states of India, where low female literacy, combined with low social status of women, has resulted in keeping them oppressed in the name of community, culture, tradition, family honour and religion is obviously negatively affected.

The failure to address the socio-economic and political roots of the continued poor health of our women has been one of our biggest tragedies. The other, of course, has been the 'misdiagnosis of women's health problems, the 'misprioritisation' and propagation of demographically driven technological fixes, as the ultimate solution to women's health problems. No other 'high-risk' population group has received as much academic and lay attention and interest in recent years as the female sex. The above average risks of this group have been especially highlighted for health and survival at least partly because these risks are easier to observe and measure than are sex differences in other indicators of welfare such as employment opportunities, wage rates and control over resources.

However, we have now passed the stage of establishing that gender differences in health and mortality do exist, especially in the South Asian region; and may even have widened over time in some areas, although, the overall trend is probably towards a closing of the gap. The more interesting question now is how these sex differentials come about, that is, to use the language of Mosley and Chen what are the 'proximate determinants' of health and mortality responsible for the sex differential and, in turn, what aspects of the female situation lead to such sex differences in these proximate determinants?

First, there is the effect of women's real or potential economic independence. How does this differentially affect the exposure to illness in males and females? The evidence is mixed. Economic activity can improve things for women through indirect things such as knowledge, autonomy and control over resources, but this has to be balanced against the hazards of employment,

- (a) in a time schedule that is packed to begin with,
- (b) in activities which carry special risks, and
- (c) under conditions where the host (that is, the woman) is already weakened by her other 'female' roles.

The relationship between women's economic, domestic and reproductive roles and gender gap in health and survival is not clear-cut and unidirectional. To repeat just one example, while female employment may result in more equal treatment of sons and daughters, it may increase the gender gap in the exposure to and intensity of several diseases among adults. Nevertheless, the present study attempts to accentuate the fact that where women are economically active, not restricted to the domestic domain and not defined primarily by the number of children they bear, the gender gap in health and survival is smaller than it is for women who are cut off from economic independence, cut off from the extra domestic world and dependent on their reproductive success for their status.

Constraints on resources mediate in these relations between women's roles and gender differences in health. While there is a tendency to assume that when resources are limited, things worsen for females much more than for males (for example, World Bank 1991). However, it appears that the poor believe in greater gender equality. This is evident, for example, in the smaller sex differentials in mortality typically found in the lowest socio-economic groups (as defined by factors such as caste, income and education) and suggests that women's roles are the intervening variable that determine the relationship between poverty and the sex differential in physical well-being. If women belong to high risk categories in all socio-economic classes then certainly a further constrain on resources might increase their disadvantage. But women's roles themselves seem to be conditioned by socio-economic status.

That poverty cannot be the excuse for such gender inequalities is also suggested by interregional analyses. For example, as pointed out by Sen (1987) and others, sub-Saharan Africa is a prime illustration of the fact that greater poverty and greater gender disparities in physical welfare need not go together.

At the same time, it is also true that even if sex differences in health and mortality rate now less adverse to females, there is much of female ill health and mortality that is still 'preventable'. That is, in a situation of no discrimination, conscious or otherwise, there would continue to be a marked sex differential in health and mortality but the direction of this differential would be reversed, with males bearing the larger brunt. If this is the natural situation, then, even with similar health and mortality levels in the two sexes, we are still not close enough to the ideal of gender equality in opportunities and treatment that a truly egalitarian system should aspire to.

The levels and distribution of income, the social and cultural practices and perceptions, the choice of technology with its impact on the occupational and natural environment, all these factors influence and are in turn influenced by the physical and mental health status of a society.

PARAMETERS OF WOMEN'S HEALTH

Usually the parameters used to assess women's health status mainly reflect the demographic concerns. Gender desegregated data is often not collected. Review of research papers and documents reflects the proliferation of material on demographic-related studies, but paucity of material on women's morbidity, suffering and pain. There are tremendous differences in the health status of our people in different states, within different parts of the same state, between the genders and between different caste and class group interest in the same place. Desegregated data is essential for realistic planning, decentralised decision-making and ensuring that policies and programme are need-based. However, the following are the vital parameters indicative of women's health in any society.

Gender Discrimination

It is noteworthy, especially in the Indian milieu, that the female counterparts always remain sidelined and marginalised. The reasons may vary from social bias and cultural coercions. Peter Adamson's arguments in this regard are of special importance. They are as follows:

As a child, woman may endure genital mutilation in order to sexuality and protect marriage ability. As a menstruating girl, she may be set aside as unclean, polluting, and made to feel dirty and ashamed. As a teenager, she may be married to someone she does not know, and made pregnant before her own body is fully-grown. As a woman unable to bear children, she may be abused and abandoned, even though it may be the husband who is infertile, or even if her infertility is caused by a sexually transmitted disease originally contacted by her partner. As a pregnant woman, she may be denied the basic consideration, the rest and the food and the antenatal care, to which she is entitled. As a woman in labour, she runs the risk of dying from the obstetric care, and sustaining injuries and disabilities for which she will not receive treatment. As a woman enduring a prolonged childbirth, she may be left to die alone and in agony, the baby asphyxiated inside her, in societies where men interpret obstructed labour as a sign of unfaithfulness. As a woman suffering from a childbirth injury, from a still-open artery or a ruptured uterus, she may die because her husband will not allow her to be seen by a male doctor.

As the mother of baby girl, she may be blamed and beaten despite the fact that it is the chromosomes of the make that determine the sex of the baby. As a wife, she may be forced to submit to sex within a few days of giving birth, or subjected to violence if she refuses. As a new mother, she may be expected to become pregnant again before her body has recovered. And finally, even if she has sustained an injury or infection that is serious and treatable, and even in those rare cases when health workers seek her out knowing that she will not come to them, she may still not be allowed to go into hospital because there will be no one to cook the meals.

One of the practical forms of discrimination and one, which has far-reaching implications for women, is the preference accorded to the boy child over the girl child, as in India. This practice, denies the girl child good health, education, recreation, economic opportunity and the right to choose her partner, violating her rights. The birth of a son is welcomed with celebration as an asset, whereas that of a girl is seen as a liability, an impending economic drain.

Though, Article 28 and 29 of the Convention on the Right of the Child lays that education should be directed to the development of child's personality, talents, and mental and physical abilities to the fullest potential, this aspect has deplorably neglected in the country. Poverty, early marriage, helping parents with housework and agricultural work, distance of schools from their homes, high cost of schooling, parents' illiteracy, and indifference and lack of positive educational climate are responsible for many evils like high drop out rates and consequently female illiteracy, ignorance about health awareness, morbidity rate, maternal mortality rates etc.

Sex Ratio

As a vital pointer of woman's health status, the sex ratio of a country marks an important place. It is found that the number of females per 1,000 males, which should be more favourable to women due to their biological advantage, is inverse in India (971 : 1000). Many factors are responsible for such disproportionate sex ratio, some of them needing an urgent attention.

Female Foeticide

In India, the life of a female child can be summed up in four words—decimation, discrimination, deprivation and degradation. In the first stage of life, from conception to childhood, it is decimation and discrimination; in adolescence, deprivation is added; and finally to fuel the furnace in which she suffers, we add degradation, i.e. through abuse, dowry, deaths and *sati*. Mr. Hingrani, the Supreme Court lawyer, advocated abortion of female foetuses, which not only amounts to discrimination of female child but also leads to the lowering

of the women's status. India's twin pressures of family planning programmes and dowry, especially the former, has brought female foeticide to such shameful proportions.

The use of sex pre-selection technology and use of killing the female embryo in the womb (amniocentesis) are some of the blatant instances of how advancement in science is abused and misused. The demographic balance provided by nature has worsened. The upset in the balance of the social structure is already having its serious repercussions and has led to polygamy, rape, and further degradation of women. The incidence has been increasing in alarming proportions.

Maternal Mortality Rate (MMR)

The number of maternal deaths (per 100,000 live births) is a significant yardstick to gauge woman's health status in any country. The major causes of maternal mortality in India are anaemia related and due to lack of rational management of high-risk mothers and of those needing emergency obstetric care. For every women who dies during child birth, around 18-20 women survive with complications, for example, cervical lacerations, sepsis, toxæmia, haemorrhage and abortions, pelvic inflammatory diseases, anaemia, uterine or bladder prolapse and other problems of the reproductive tract. Besides, women also suffer from communicable diseases, malaria, viral hepatitis, tuberculosis, rheumatic, and heart diseases during pregnancy, giving rise to a high rate of maternal mortality and morbidity. Poor health, poor nutrition and prolonged closely spaced periods of fertility, stretching from adolescent to menopause are some other factors that contribute to maternal mortality. Maternal also puts women at increased risk of bleeding to death during delivery, and accounts for 20 per cent of all maternal deaths.

FEMALE LITERACY

Literacy rate among women is also responsible for high/low rates of MMR, Infant Mortality (IMR), birth and cases of female foeticide and dowry deaths.

Due to many socio-economic and cultural prejudices most of the girls in the rural areas are not given the right kind of

schooling. Most of the families in the rural pockets want their daughters to take care of the younger siblings and perform household works. Fear of sexual harassment and sexual violence prevents many girls from attending schools that have male teachers, are located far from their homes or even outside the village, or with an overwhelming number of male students. There is also the added fear of not being able to get a groom with a higher educational qualification than the daughter.

Access to Health Care Services

Free and well designed state health services which are more accessible and affordable to the poorest of the rural poor is also a determining factor for women's health. Anaemia is widely prevalent among women and even rampant in adolescent girls. In India, 60 per cent of all women are undernourished with weight less than 40 kilos, 12-30 per cent are stunted, and 60 per cent are anaemic by their last trimester of pregnancy. Anaemic women are immune suppressed and experience higher rates of morbidity, especially from urinary and reproductive tract infections, which are associated with Low Birth Weight (LBW) babies, prematurity and growth retardation. Low levels of health service utilisation and the poor quality of health care, overburden of work shouldered by women gives rise to constraints making it difficult for them to seek health care.

In early adolescence, because of a growth spurt associated with puberty and onset of menstruation, the nutritional needs of a girls increase, especially of iron, vitamin A, calcium and iodine. Denial of adequate food to girls, partly due to non-availability and partly due to discrimination, continues to be a major problem. An inadequate diet has life-long consequence for girls, as their growth and development is jeopardised. Early marriage and early pregnancy further deplete their inadequate reserves. Rising food prices, limitations of the public distribution system and shift to non-edible cash crops, has also worsened the existing nutritional status of women.

Family Planning

India has a population of more than 100 million people. In spite of spending Rs. 111 crores on Maternal Benefit Scheme

demographically driven population control programmes, maternal benefits schemes and post-partum programmes have not been much helpful to lift the fate of the women. Since 1951, neither have contraceptive needs been met, nor has the birth rate come down significantly, except in a few states like Kerala.

Reproductive Health Problems

Reproductive Health Problems of women in the country have also not been seriously viewed and they need to be taken up enthusiastically by one and all. Some of the problems that have long stunted the growth of the women's development are as follows:

Abortions

The spiralling number of abortions and abortion deaths needs to reflect the increase in the number of inflicted, unwanted pregnancies, which women have to bear even at the cost of death, profuse bleeding, sepsis following abortion, sense of shame and guilt.

Infertility

Though, it is a medial problem the social brunt of such defect grows in giant proportions in the family and also in the society, causing a life-long torture, especially for the woman spouse.

Other pervasive morbidity like semi-starvation, anaemia lead to debilitating health, tuberculosis, latent gynaecological problems, sexually transmitted diseases, contraceptive induced disorders and cancer of cervix. Particularly, the incidence of cancer of cervix in Indian women is the highest in the world.

Reproductive Tract infections like sexually transmitted diseases (e.g. gonorrhoea, syphilis, trichomonas Chlamydia, HIV, AIDS), candidiasis or endogenous overgrowth during pregnancies, dysmenorrhoea or painful periods, infertility, discharge, sepsis during pelvic examinations have seriously contributed to women's health issues that need to be addressed appropriately.

Mental Health

In depressive disorders and self-inflicted injuries affective women between the ages of 15-44, India ranks 5th and 6th amongst diseases and injuries (World Development Report, 1993), The major causes of such depressive disorders are attributed to childlessness, physical, sexual and mental abuse, widowhood, desertion, conflicting demands of domestic and income-generating roles, a combination of work pressures and harassment at work etc. Sexual harassment at workplace should be treated as an occupational health hazard as its causes damage to both physical and mental health of women. Women workers working in foreign land have often reported sexual harassment and torture by employers and agents.

Women's health is determined by the forces working at homes, workplaces, society and the state. According to Dr. Amartya Kumar Sen, "Burden of Hardship falls disproportionately on women" due to seven types of inequality—mortality (due to gender bias in health care and nutrition), natality (sex selective abortion and female infanticide), basic facility (education and skill development), special opportunity (higher education and professional training), employment (promotion) and ownership (home, land and property) [Sen, 2001].

Women and Work

Girls start working earlier than boys, work longer and harder throughout their lives. The poorer the family, the harder the women and girls have to work. The energy consumption in mere survival tasks of fetching fuel, water, fodder, care of animals, washing, cleaning results in negative nutritional balance and calorie deficit. Even when women work outside the home, they do not get equal wages for equal work and are made to perform unskilled jobs which are poorly paid, more hazardous and demanding. Women involved in specific occupations face various occupational health hazards. Such environmental and occupational hazards are more serious in women working particularly in bidi rolling, electronic assembly line, stone quarries, pesticide industries and also with the women working in health care wards in hospitals.

Lack of Power—Lack of Choice

An unequal power relationship exists between the genders. Women continue to lack the freedom to make their own choice, whether it is in the matter of remaining single, getting married or selecting the person they want to marry. After marriage, the pressure to produce a male child within nine months of marriage has forced the reproductive role on many young women. This has had a number of far-reaching, negative, physical and psychological consequences. When the question of an unwanted marriage cannot be challenged, it is unlikely that its consequences, an 'unwanted pregnancy' can be meaningfully challenged.

Article 2 of the Conventions on the Right of Child, in a number of recommendations has accentuated upon the principle of equality before the law and forbid gender discrimination, including the adoption of legislation prohibiting harmful traditional practices such as genital mutilation, forced and early marriages of the girl children, early pregnancy and related prejudicial health practices. However, early marriage is another serious problem that robs a girl of her genuine rights. It inflicts great emotional stress on her both physical and psychological health.

Male Responsibility

The issue of male responsibility in matter of contraception, STD, AIDS, sexual violence, growth of red light areas, trafficking of women, spread of pornographic literature and blue films, growing market for aphrodisiacs and male potency drugs, promotion of sadomasochism, escalation of male violence, paedophilia, and child sexual abuse need to be addressed.

Sex Determination and Female Foeticide

In 1982, the women's movement highlighted the increasing incidence of female foeticide following the use of sex determinations. However, authorities grudgingly acknowledged the problem only when census data and numerous studies pointed to the worsening of the sex ratio at the national and state level.

Introduction

Sex bias or son preference places the female child in a disadvantageous position from birth. In some communities as in India the practice of infanticide ensures that, some female children have no life at all violating the basic right to life laid down in Article 6 of the Convention on the rights of the child. Selective abortion, foeticide and infanticide all occur because the female child is not valued her culture, or because certain economics and legislative acts have ruled her life worthless.

As unborn children, they face covert violence in terms of sex-selection and overt violence in terms of female foeticide. After the use of aminocentesis, chorion villai biopsy, sonography, ultrasound, imaging techniques IVF (In Vitro Fertilisation) clinics for assisted reproduction are approached by the infertile couples to produce sons.

Access to Food and Nutrition

Rising food prices, limitations of the public distribution system and shift to non-edible cash crops have certainly given rise to the nutritional status of women and they must be singled out as important parameters of women's health.

Malnutrition is common among all sections of the Indian population, but is of greatest consequence and seriousness in women. Poor nutritional status and iron deficiency also increase the risks of death and disability especially during pregnancy and childbirth.

Violence Against Women

Violence against women is regarded as major women's health issue. It is a worsening public health. Domestic violence as a result of differences regarding birth control practices, number of children, birth of a girl child—should be treated as a serious social problem and respect should be given to bodily integrity of women. Pregnant rape victim within or outside marriage should have a final say regarding continuation or termination of her pregnancy.

Crime against women in the form of sexual harassment is rampant day by day. Adding to it there are numerous instances of domestic violence, sexual abuses, marital rape, forced

prostitution, neglect of widows and elderly women, immoral trafficking of women that ruffle the tranquillity in women's life. Gender based violence, on the other hand has serious repercussions like unwanted pregnancy, forced abortion, miscarriage of a wanted baby, STDs/HIV/AIDS, gynaecological problems, head injury, broken bones, depression, suicidal tendencies etc. Eighty per cent of rapes are perpetrated by relatives or men known to the women, 24 per cent of rapes involve young girls, less than 16 years of age (India Country Report, World Congress for Women, Beijing 1995). Increase in rape to take revenge on the men folk, during communal violence and for trade and blackmail have also been reported.

Scope of the Study

In this work, deterioration of the health status of women is not studied scientifically or in the scientific ways, rather it has been studied from the socio-economic point of view. Since women's health status needs a holistic approach, an attempt has been made to concentrate on the clinical approach as well.

This study is important from public health point of view because Orissa occupies a low status in women's health related concerns. Whereas the states like Kerala, Tamil Nadu, Goa, Maharashtra and Punjab have achieved a considerably higher level, the states like Uttar Pradesh, Madhya Pradesh, Bihar, Rajasthan, Jammu & Kashmir, Assam and Orissa are performing much below the national level. This has been a matter of great concern because these states also happen to be very populous and unless performance in these states improves, the national performance will continue to remain depressed.

The results at ground level are influenced by a number of factors like investment for programmes at National State level, efficiency of the state health system and response of the people. Although, the overall literacy rate in Orissa (63.6%) almost approximates to the national literacy rate, India (65.30%—Census Report, 2001), the gender disparity in Orissa is alarming. The State's female literacy rate of 34.68 per cent is lower than the national average (39.29 per cent). Twenty districts out of the State's thirty districts have female literacy rates lower than the national average. Literacy rate for scheduled castes is 36

Introduction

per cent, for scheduled tribes is 22 per cent. Female literacy rate in seven districts is below 30 per cent (Gajapati: 28.91, Kalahandi: 29.56, Koraput: 24.81, Malakanagiri: 21.28, Nabarangpur: 21.02, Nuapada: 26.01, Rayagada: 24.31); In four districts it is below 40 per cent (Boudh: 39.78, Bolangir: 39.27, Kandhamal: 36.19, Mayurbhanj: 38.29); In four districts it is below 50 per cent (Ganjam: 47.70, Deograh: 47.56, Keonjhar: 46.71, Sonepur: 47.28). The percentage of population in districts below low literacy rates and the percentage of population Below Poverty Line (BPL) show a positive co-relationship between low female literacy and the incidence of high poverty. In this, Ganjam district marks 55 per cent Below the Poverty Line. These trends in low female literacy rates, and poverty have always remained causes of concern, which invites a lot of public attention and serious contemplation by one and all. The researcher being an inhabitant of Brahmapur city in Ganjam district has no greater a cause like the pitiable condition of women's health status in the district that propelled him to undertake a study like this on women's health status in one of the slum areas of the city.

Taking the above factors into account, the present study assumes the responsibility of making an in-depth analysis of the deplorable status of women's health in one of the urban slums of Brahmapur city called Dimira Bauri Sahi, Gosainnuagaon, in the suburbs of Brahmapur city in Ganjam District of Orissa. The area selected for the study is thought to be a sample representative of the urban slums of any part of the suburb of our cities in India. The scope however is limited by virtue of its sample size and coverage, since only a few socio-economic issues pertaining to women's health have been chosen for analysis and most part of the clinical approach to the health related issues of women's fall out of the scope of the present study.

Objectives of the Study

The present study seeks to verify the major premises of health parameters as specified by the National Commission on Health in relation to the sample women population taken for the present study in the urban slums of Brahmapur city, in Ganjam district of Orissa.

The specific objectives of the study however underlines the following to be examined in detail to find out the health status of women living in the urban slums of Brahmapur city, in the district of Ganjam in Orissa.

- To find out the different ailments that victimise these slum women in the studied area and to find out the different health care amenities to which the women have access in the urban slums.
- To find out the different socio-economic factors that might be directly or indirectly affecting the health status of women in the urban slums.
- To study the nutritional and dietary habits of the sample population in order to find out the causes of the morbidity.
- To find out the level of health awareness among women living in slum areas.

Review of Literature

Ranging from Anthropology to other Social Sciences like Economics, Political Science, Home Science, and Medical Sociology, plethora of literature is available on the women's status in the society. Taking stock of the paradoxes of interpretation on women and her position of the society, the present literature survey takes into account only the topical discussions on women's health status, both at home and abroad. This review attempts to examine the quality of information in important contributions to the field providing also a picture of women's health status from both social and clinical approach.

Sen (1985) postulated that even when under the impact of global and national level macro-changes, improvement comes, women's inferior position gives them inferior access to the improvements and thus disparities between men and women are widened. He pointed out how under such circumstances men move to commodity production and urban jobs while women continue to remain in subsistence production. The household structure which gives preference to men in power authority, property rights and as bearers of lineage, gives also preferential access to development benefits. "While reproduction is a central

Introduction

cooperative aspect of life the differential role of men and women has a profound effect on the bargaining position of women".

Belenky *et al.* (1986) found that despite the pervasiveness of chronic illness, knowledge about women with chronic illness is minimal. The growing body of literature on women's roles, development, and cognitive processes is helpful in considering how chronic illness may affect women's lives. In general, women value their connections to others and their interdependence with others. Women live their lives around the themes of caring for others, responsibility and empathy. For women with chronic illness, then, the family and the social context become crucial in understanding how women are affected by and manage chronic illness.

Kamala (1982), in her study on the Kottai Pillaimar tribes found the gender discriminations lying more in a cultural and social organisations rather than the universal female subordination.

Shiva Kumar (1993) focused on gender biases in health, the unfavourable levels and trends in female-to-male ratios in the population base. Besides, he attributed poorer health conditions, reproductive tract infections, inadequate nutrition and dietary habits and many other socio-economic and cultural factors as responsible for the growing morbidity and mortality among women.

Panda (1997), in his study of rural Orissa, found a correlation between poverty and woman's matriarchic roles in the family and society. He inferred that targeting education along with other social-oriented programme towards women could prove helpful to aggrandise women's health status.

Meheta (1973), raised a pertinent question of social justice for women in an egalitarian society, where economic development stresses the benefits that result from higher production, expanded consumption and better employment opportunities, but only through the social fabrics of self-regulation and associative effort.

Richardson (1987) while enquiring into the disproportionate affects of rural poverty on women found that although rural women enter the labour force, many are working in low-skilled,

low wage jobs. He stressed upon the point to recognise the diversity of poor women and the multiple reasons for their lives of poverty. Some of these, he concluded are divorce, chronic illness, job-related injuries, involvement in low-wage occupations and loss of income with health of a spouse.

Belle (1990) related the women's health problem issues to their inherent poverty, and their employment in low paid jobs. He found that despite women's growing representation in the labour force, women are still over-represented in low paying jobs. Not surprisingly, poverty is one of the major social issues affecting women's lives and their health.

Browning (1976) made an incisive study about the constitutional and legal validities of both the official and non-official provisions that profess to come to the rescue of women in the society. He found the solution to such problems only in motivating the men and women for a persistent awareness of their respective rights and obligations towards one another.

Park (1989) defines health as a "modus vivendi enabling imperfect men to achieve a rewarding and not too painful existence, while they cope with an imperfect world".

Reddy (1994) pointed out that the per capita income and female literacy plays a crucial role in improving the health status of the Indians. From his study, he inferred that all the policies had to be directed towards economic growth and alleviation of poverty and female literacy.

Rao (1991) stated that "improving health scenario indicates the optimum integration of various factors such as development of infrastructure in rural areas, urban slums and tribal areas, both in terms of physical facilities as well as manpower development, community involvement and participation to achieve health for all by 2000 A.D."

Srinivasan (1993) in his article "Health Care in Rural Areas" averred that the acceleration of the pace of the health programmes is an urgent imperative and much more concerned effect and substantially larger investment is vital for rapidly improving the health profile of the country.

Padmanavan *et al.* (1994) found that the health care utilisation is characterised by low coverage due to

- (i) Distance and time,
- (ii) Unequal distribution of health services, and
- (iii) Inadequate facilities in public health centres.

In line with the definitions of the WHO, Adams & Moss (1995) studied the nutritional standards of health and food deficiencies and found that disease of an infectious and toxic nature caused by, or thought to be caused by, the consumption of food or water. A diet may provide adequate protein and energy but be lacking in specific rise to characteristic deficiencies such as goitre (iodine deficiencies) pellagra (nicotinic acid) beriberi (thiamine) and scurvy (ascorbic acid).

In order to find the adverse of poor dwelling, Chakarvarti (1995), studied slum life and defined slums as "areas of buildings are unfit for human habitation; or are by reason of dilapidation, overcrowding, design of buildings, narrowness of streets, lack of ventilation, light or sanitary facilities or any combination of these factors, are detrimental to safety, health or morals."

Nakkeeran (2003) has attempted to bring out the conditions of work, status and their relationship with child mortality and how it affects the level of fertility. The study aimed to explore the comprehensiveness of the term 'conditions of women work' and how it reflects the entire milieu of a woman's situation.

While studying the perpetuating violence on the weaker sections of the society, Goode (1971), attributed the motif of the phenomenon not in a socio-economic disparity between the spouses but rather in a macho attitude that always want to establish their masculine difference and of power and control within the relationship. He found that violence is rather linked in socio-demographic indicators of structural inequality.

Omvedt (1990) however, criticised Goode's proposition of over-generalisation, since the pattern of reported cases did not appear to substantiate the observations of some scholars who argued that domestic violence is more of a middle class behind-closed-doors phenomenon, bound by notions of privacy while

women of lower classes are more often subjected to rape and sexual assault or forms of violence outside the domestic realm.

The principal duty of women has been viewed as bearing children, particularly sons, and serving as the foundation of families. The cost to the women's health of discharging this duty goes unrecognised. In the discussion on the low status of women, their contribution to the unorganised sector and their invisibility in their productive role is often discussed. The Government of India therefore appointed a commission to enquire into the conditions of women working in the unorganised sector, which brought out a detailed report describing the conditions of the women Government of India, 1975). Several efforts are also made to discuss women's invisibility in data. However, greatest invisibility of women prevails in health issues. Health is the basic need of a human being and therefore denying women their health needs has affected seriously their productive and reproductive roles. It has also to be noted that the health and wellbeing of the members of a family is far more dependent on the productive capacities of the woman than that of any other member of the family.

At the Alma Ata conference in USSR, in 1978, primary health care was exclusively discussed by 134 countries and access to family planning, maternal and child care and prevention of common diseases was accepted as a basic human right (WHO, 1978).

Women play an enormous role in maintaining the health care system through their caring work at home, in the family, in the neighbourhood and in the health professions, as nurses, midwives, physicians, etc. at present, more than ever, the health services depend on the caring work of women, add their skills and capacities. Yet the development is not matched by women's participation in the health care decision-making.

Generally, there has been medicalisation of women's normal life and bodily functions, such as menstruation, menopause etc, or social issues are seen as medical problems requiring medical solutions. This has resulted in shifting the control from an individual to the medical profession. This means loss of control

and confidence in women's own capacities and in their own bodies, (WHO, 1985).

Haberman *et al.* (1990) investigates into the interpersonal, intra-personal and environmental demands or hardships imposed on women by chronic illness.

Rodin *et al.* (1990) in their study found that women's changing lifestyles, institutionalised sex role expectations, health care delivery, and changing biology are the important factors for the future health prospects.

Stellman (1987) examined exposure to toxic substances in the workplace, calling attention to physical, chemical and biological hazards of the workplace and occupational stress.

As for the Reproductive Health of Women, there is copious literature by different authors, some of which is reviewed in this study.

Sai *et al.* (1989) in their study propositioned that Reproductive health care strategies are to meet women's multiple needs that included education for responsible and healthy sexuality, safe and appropriate contraception and services for sexually transmitted diseases, pregnancy, delivery and abortion.

As for the observations of the WHO (1978) about the reproductive health of women it clearly says that "people are able to have responsible, satisfying, and safe sex life and that they have capability to reproduce and freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed of and to have access to safe, effective and affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant".

It further adds, "The basic elements of reproductive health are: responsible reproductive or sexual behaviour, widely available family planning services, effective maternal care and safe motherhood, effective control of reproductive tract infections

(including sexually transmitted diseases), prevention and management of infertility, elimination of unsafe abortion, and treatment of malignancies of reproductive organs. Furthermore, reproductive health affects and is affected by other aspects of health, most particularly HIV infections / AIDS, nutrition, infant and child health, adolescent health and sexuality, life-style and environmental factors. Pervading and affecting all aspects of reproductive health are various social and cultural factors, but especially the status of women in society.

Grant (1991) observed that women get mentioned in the programmes for reducing high infant and child mortality. However, they hardly receive attention in matters of their own health. Thus, far greater variation prevails in conditions that govern women than those that govern infants. The foundations of reproductive health of women are laid in childhood and adolescence, and are influenced by factors such as nutrition, education, sexual roles and social status, cultural practices and the socio-economic environment. Women's health is seen only as means to achieve other social goals rather than end in itself. Women's needs are either unserved or are underserved and women suffer from several problems with the key aspects of sexuality and reproductive health due to childbirth, violence against girls and women.

Macklin (1989) stated that there are three fundamental ethical principles in women's rights for the reproductive freedom. These are liberty, which guarantees the freedom of action; utility, which defines moral rightness by the greatest good for the greatest number; and justice, which requires that everyone has equitable access to necessary goods and services, under this framework Governments have an obligation to provide information and services for women to exercise their rights to reproductive freedom. The feminist argument for reproductive freedom is based on rights to equality, self-determination and human dignity.

Pillai (1995) found that behaviour change in dietary and health practices necessitates reaching women with health and nutrition information. Counselling and services, as well as supplemental food, she averred, will go a long way in bringing

The literature survey reveals that in different areas of social science a plethora of literature have focused as women's health and related problems. But so far no indepth study has been made as the health status of women in Orissa, more particularly in Ganjam district in South Orissa. The district is not as backward as the hilly districts of Orissa, yet the people are very conservative so far hygiene and health are concerned. The general level of economic development has not percolated down the poor people. Brahmapur being the heart of the district and main business centre people from nearby villages as well as neighbouring Andhra Pradesh come to the city in search of work and livelihood. Thus several slums have come up in the city in its periphery. Keeping in view the paucity of research on the health problems of women, this study attempts to explore the health status of women in a selected area of Brahmapur.

Methodology

The sources for the study consist of both primary and secondary sources of data. The primary sources consist of questionnaire and schedule, while the secondary sources comprise of a number of books, records, journals, National and International Reports, Reviews, Websites and Government offices both public and private and Non-Governmental Organisations (NGOs).

After going through the different available written material from primary and secondary sources, it is impressed to study the problem of women's health status in its two important dimensions—social and clinical.

Secondary data collected from MKCG Hospital, Brahampur, and Central Government offices and local office of Ganjam district. From the primary data, survey was carried out and the different roles of different agencies are studied. Government plans and policies are studied in comparison to the WHO parameters. Contribution of NGOs and Government agencies towards bringing round an overall growth in the health perspectives of women vis-a-vis the ground realities have been made.

With the secondary data, simple tabular calculations are set up to study the future prospective of women's health

conditions. Critical analysis is made to through the clinical approach. The secondary data for last 5 years are taken into consideration. The data of the recent years is taken physical verification.

Sample Design

The data comes from 101 sample respondents of Dimira Bauri Sahi, one of the urban slums located in the heart of Brahmapur city, in Ganjam district where most of the inhabitant families are poor, illiterate, scheduled castes who are even in these days of technology and advancement are considered low in status. For the purpose of obtaining data, prior to the survey, a pre-designed questionnaire, after careful scrutiny was prepared and administered among the sample respondents. Since the questionnaire contained most sensitive questions pertaining to women's health status and gynaecological issues, the researcher had to take the aid of an Anganwadi Health Worker, to help him in the survey work. Moreover, apprehending that the women may reclude their responses before a male interrogator, the help of a women health worker who was familiar to the people in that area became indispensable. The questionnaire contained 40 vital items relating to women's health status, their income, hygiene, health awareness, literacy level, nutritional status, working condition and psychosociological background.

Data Collection

The purpose of the present research is to obtain valid and reliable information through the structured questionnaire administered as appropriate tools for obtaining needed research data from the 80 households, in Dimira Bauri Sahi, a slum in the heart of Brahmapur city. After data was collected the same was classified, tabulated and then treated statistically to drawn inferences relevant to the study.

Thus, the questionnaire method has been adopted in the present study. However, interview method was also adhered to as and where felt necessary, as a combination of these two yielded a full picture of various subtle nuances of women's health status besides achieving the survey objectives and providing a scope of the investigator to be acquainted with the

Introduction

25

concerned topic of Women's health status in the chosen area. The data so obtained were put to the rigours of simple statistical analysis, in tabular forms and the percentage and trends were drawn.

Chapter Theme

The study has been divided into five chapters. In this "Introduction" Chapter-1 along with conceptual framework, parameters of women's health, scope and objective of the study, methodology; data collection and review of literature have been presented followed by the analysis of field data in the subsequent chapters.

Chapter-2 on "Status of Women in India" presents a descriptive analysis of the socio-economic condition and health status of women in the state of Orissa in the general framework. Health and medical facilities available in the state for the women and nature of employment for them in the state are analysed.

Chapter-3 on "Socio-Economic Conditions of Women" on the basis of field data collected for women from the sample colony has been analysed. The level of education, their housing pattern, availability of water along with nature of income and expenditure pattern and general environment in the sample colony has been discussed.

Chapter-4 on "Issues on Women's Health" the core chapter of the study, exclusively analyses the health condition of the women and availing of the medical facilities provided by the government. Prevalent of different types of diseases among the women, dietary provision for normal, pregnant and lactating women, nature of antenatal and neonatal care, use of different devices adopted by women for family control and the system and place of delivery chosen by women are analysed in detail.

The final chapter, Chapter-5 "Findings and Conclusions" provides the main findings of the study and brief conclusion followed by select bibliography and indices.

2

STATUS OF WOMEN IN INDIA

This Chapter presents a picture of decline in sex-ratio of women, female literacy, problem of girl child, women and development and discrimination on women in a macro perspective. Based on historical facts this chapter is devoted to analyse the policy perspective on women with special reference to state of Orissa.

It was Raja Rammohan Ray in early 19th century, who first raised the voice against the exploitative religious practice on women, which was followed by other social reformers namely M.G. Ranade, Dayananda Saraswati, Anne Beast, Iswar Chandra Vidyasagar and in the twentieth century by Mahatma Gandhi. Though some legislative measures were taken to allow widow marriage and for the prevention of child marriages, in practice, the social reformation moved slowly. Even in the twenty-first century the widow marriage has not been accepted fully in the social system and child marriages are still in practice.

Hindu philosophy is dual in character in analysing women's values. Women seem to have been successful in creating a myth that Indian woman possesses great power but not in practical terms (Desai, 1987). The status of women in Orissan society is not different from the Indian mainstream; even in some spheres it is worse than their counterparts in other states. Rather women in Orissa are far behind in their socio-economic status. The reasons of women's lower status in Orissan society is due to the stronghold of traditional values which perhaps is inevitable in a traditional agrarian economy with lower rate of urbanisation and upward economic mobility.

DEMOGRAPHIC FEATURES

The population of Orissa as per census of 2001 is 3.67 crores which forms about 3.58 per cent of the total population of the country. The female population is about 49.29 per cent in the state. The decadal growth rate of population between 1991 and 2001 is 15.94 which is one of the lowest among the states of India. Out of the total population the scheduled castes form about 16.20 per cent and the scheduled tribes of 24.21 per cent. The state is primarily a rural state where about 87 per cent of people reside in the rural area and the urbanisation forms only about 13 per cent, one of the lowest percentages of urban population among the states.

The sex ratio of Orissa is now 972 according to Census of 2001 which gradually slowed down from that of 1086 from the year 1921. It can be verified from Table 2.1 that the sex ratio of Orissa remained higher to Indian ratio throughout the twentieth century. Up to the year 1921 the sex ratio, that is number of female per thousand of men remained above 1000 in the state, but thereafter it has been declining trend. It is found that the difference between the sex ratio of Orissa and India gradually narrowing down during the last century, from 131 in 1921 to 39 by 2001.

RURAL AND URBAN SEX RATIO

The declining trend is observed in case of sex ratio of rural population of Orissa, but interestingly the sex ratio of urban Orissa showed an increasing trend since 1961. In the year 1961 onwards till 1991, the sex ratio in urban Orissa has increased from 807 to 866.

On the whole throughout the twentieth century the sex ratio in urban Orissa remained less than rural Orissa. The reason behind this contradiction may be due to the rapid growth of urbanisation and industrialisation in the state since 1961. Another trend reveals that the rural sex ratio up to 1971 remained more than one thousand and thereafter remained below 1000, on the other hand in urban population from the beginning of 1921 it remained less than 1000. Apart from the declining sex ratio, Orissa shows a stagnant Crude Birth Rate

(CBR) of 26.2 per 1000 population. In India the urban sex ratio shows declining trend in comparison to rural sex ratio. Orissa's CBR is lower than the national average of 27.4 but it is still higher to many states like Kerala (17.8), Punjab (23.5), Maharashtra (23.2) and Tamilnadu (19.2).

Table 2.1 : A Comparative Picture of Sex Ratio of Orissa and India

Year	Orissa	India	The Gap
1921	1086	955	131
1931	1067	950	117
1941	1053	945	108
1951	1022	946	76
1961	1001	941	60
1971	988	930	58
1981	981	934	47
1991	971	927	44
2001	972	933	39

Source: Census of India, 2001.

Table 2.2 : Trends of Rural and Urban Sex Ratio in Orissa

Year	Rural	Urban	Total
1921	1089	963	1086
1931	1071	924	1067
1941	1058	914	1053
1951	1029	851	1022
1961	1015	807	1001
1971	1002	845	988
1981	999	859	981
1991	988	866	971
2001	986	895	972

Source: Census of India, 2001.

Table 2.2 provides separate figures for sex ratio of rural and urban population.

Problems of Girl Child

India is a developing country going through demographic transition, where imbalance in the sex ratio of different age groups, such as new born and juvenile has become a major cause of concerns. Sex composition of population needs intensive research and attention of scholars.

All children must enjoy equal rights irrespective of their sex, race, colour, and religion. Though, male and female both form an edifice of human society, the girl child is considered to be a lesser child in our society. Irrespective of class, caste and economic conditions, she is discriminated against and neglected at all levels, resulting in the denial of basic services, needed for her survival, welfare and development.

The girl child is perceived as a burden to be passed on to another family. Her contribution in the household economy is unacknowledged. The adverse attitude towards the girl child signals the catastrophe of serious demographic imbalance and degeneration of socio-economic conditions. Unfortunately, the rejection of the unwanted girl begins even before her birth. Prenatal sex determination tests followed by quick abortions eliminate thousands of female foetuses before they can become daughters. Those unfortunate girls, who manage to survive till birth and beyond, find the dice heavily loaded against them. In a male dominated society, girls are denied equal access to food, health care, education, employment and even simple human dignity. Her sacrifice and dedicated services ensure the well being of the family, but in return, she receives neglected childhood devoid of proper education and health care.¹

The girl child is abused by being burdened at home with labour like cooking, cleaning and taking care of the younger siblings. Besides, the poverty stricken parents in tribal regions make small girls take up work as domestic help in a number of houses as part time workers or full time servants. The plight of tribal girl child is precarious. She is exploited sexually, abused by the male employers.²

The declining sex ratio, disparity in education and health sector, sexual exploitation, traditional and orthodox attitude towards girls etc. have played havoc in the future mother of this country. There are repeated cases of sale of child, bonded labour, starvation death, frequent outbreak of diseases in these tribal districts of Orissa (Tripathy, 1989).³

Brief Review of Literature

Women constitute half of the world's population, perform nearly two-thirds of its work, receive one-tenth of the world's income and own less than one hundredth of world's property (UN Development Report, 1980). Women spend two-thirds of their working hours on un-paid works but men spend just a fourth (Human Development Report, 1995).

Women work 12 hours more in a week than men (Human Development Report, 1995). An ILO study finds that men tend to spend 60 per cent of their income in their home and 40 per cent on themselves, where as a woman 90 per cent of her income on her family and 10 per cent on herself.

A review of the available literature on child labour and girl child labour provides an understanding of the problem confronting the nation as a whole. While much has been written about the differential status of girls and boys with respect to health, nutrition and education, not much is known about the working girl (Burra, 1995).⁴

Even during the International Year of the Child (1979), due emphasis was not accorded to girl child as concept. It was only after the declaration of SAARC decade of girl child (1991-2000) the significance of the studying girl child as a subject gained momentum. As a result of which, a national action plan (1992)⁵ was prepared which state that "this action for the girl child will help sustain the consciousness aroused all over the country and achieved the goals set for brighter future of the girl child in India within this decade (Gowariker, 1993).⁶ The ILO's Oslo Conference of Child Labour also emphasized special focus on girl child.

Jain and Chand (1991)⁷ revealed that girls between 9 and 19 years worked much harder in agricultural fields and animal

husbandry than boys of the same age, but they work less than boy in non-agricultural labour. The authors opine that the work participation rate depend on the type of work and facility available. Another important finding was that on the whole the age structure of the girl child workforce is lower than that of males. This picture is reinforced by the higher rate of non-enrolment in schools and school dropouts among girls than boys.

Aparna (1991)⁸ has focused that the girl child will be in any combination of the family work patterns like: domestic work, non-domestic work and wage work. There was no girl child employed in non-domestic wage work as a combination. The clear pattern that emerges is that girl children in the age group of 5 to 8 are involved in domestic work. As they grow older, between the ages of 13 and 15, they do all types of work, but predominantly wage work. Another significant point was that at no stage the girl child is free of domestic work; the variation is only in the time spent on this or any other type of work. It was also revealed that the total number of hours spent on work increased progressively with age. The study demonstrates that with a certain increase in family size, the study focused that over two-third of the girl children, whose brothers do not attend to work, were engaged in domestic work only.

Usha (1991)⁹ examines the concept of girl child labour in India, the extent of the problem and the working conditions. The lower position of girls in the society under-value girl child labour compared to the male child labour. Besides occupational hazards, girl children are vulnerable to sexual abuses both at the place of employment and at home when they are left to themselves. Since poverty is the main cause of child labour, girls from poor background, confront severe exploitation along with other traditional social disadvantages.

Sudesh (1992)¹⁰ made an attempt to find the reasons of girl child employment. It was inferred that low level of income of the parents, failure in school, dominance of carpet industry in the region as household and non-household industry are the factors which influenced girl children to employ themselves. Among children employed in the carpet industry, breathing problems, body aches, joint pains, finger aches and loss of

eyesight, feeling of general weakness in the body etc. are common health hazards experienced among the children.

Ghouse (1992)¹¹ depicted that many of the girls though they are living with their parents, have to earn to meet their essential needs. The parents are so poor that they cannot support their children. The health conditions of girls are more precarious. The girl street children are disgusted with the life they lead and each one of them is keen to come out of her present life.

Vijay Kumar (1992)¹² demonstrated that the prevalence of girl child labour is more in beedi industry compared to male child labour. The analysis of data revealed that children in match industry, beedi manufacturing units, and in the workshops are working minimum of 9 to 12 hours and even up to 15 hours per day. Moreover, it was found that girls work longer hours in all the age groups compared to boys.

Rao and Mallik (1992)¹³ in their study pointed out that most of girls' basic requirements are inadequately met and usually they are in the age range of 6 to 10. Their general health is moderate though they are undernourished. They are deprived of adequate clothing, medical treatment, health checkup, education and training.

Rita and Kalpana (1993)¹⁴ focus that the children assumed responsibilities at the age of 8 and most of their childhood is spent in doing various jobs both within and out of the house. Discrimination based on sex is a common complaint. Whereas boys are allowed maximum freedom, the girls are over-burdened with works. Even the health and nutrition of girls are also neglected.

Chandramouli (1993)¹⁵ highlighted the incidence of inhuman crime introduced by religion (Hindu) evolved as a custom, where the girl child is physically and economically exploited.

Narayana (1993)¹⁶ focus light on gender discrimination, problem of social development in the third world, human development index and the Kerala model of human development. Though, employment of boys and girls are associated with several abuses, girls are more abused.

Status of Women in India

33

Meera and Neeta (1993)¹⁷ endeavored to focus light on various aspects of female child labour in India. According to them, several economic and social factors are responsible for the prevalence of large-scale female child labour in India. Poverty being the important cause, old traditions and social customs do supplement for the prevalence of child labour. The death of parents and other factors force the female child to become laborers.

Chowdhry (1995)¹⁸ in his study analyzed the gender discrimination against the girl child in relation to health, nutrition, education, work participation and adolescence. According to him, gender bias has made the girl child to limp in her progress. A girl child generally never enjoys her childhood and is hastened to become mother. She is deprived of her girlhood and ultimately responsible for producing unhealthy, malnourished and illiterate girls. The cycle continues and as a result, the process adversely affects the quality of Indian society.

Kiran (1995)¹⁹ highlights the status of the girl child in socio-economic setup with reference to rural girls. In rural India, the girl child suffers from parent's bias as the daughters are treated as liabilities while the sons are treated as assets. The girls are also facing severe discrimination with regard to nutrition, health care and education. The status of girl child is directly linked with her mother's status, which is considered as inferior in rural India.

Tripathy & Pradhan (2003)²⁰ in their study pointed the problems of girl child; their exploitation, discrimination, disparity in education and health sector and finally their serious implications in India. Using secondary sources of data the study has indicated the general neglect of girl child in Orissa in the national framework.

The research on girl child labour is isolated, fragmented, meager and scanty. ILO calls for research in the area by mentioning that the available data on the causes of child labour in hazardous work as distinct from non-hazardous occupations.

Moreover, participatory research studies on child labour in specific regions or occupations are also needed to design relevant

focused projects and programmes. The situation of girl child, who is working at home and outside, whose exploitation is very often concealed, is one of particular concerns.

In this light, study of the factors influencing the sex composition of different population groups become very relevant for better understanding of different future prospects of the problem. Despite a number of constitutional safeguards and numerous welfare measures undertaken by the Government towards women empowerment, the status of women has not been adequately hoisted and they, particularly in rural areas, continue to be the most deprived and neglected lot. The declining sex ratio, low literacy rate, lower level of nutrition and health care, limited access to resources, skills and decision-making explain the vulnerable position and lower status of women in the society.

Objectives

An attempt has been made in this study to analyze the problems with the following objectives:

1. To examine the levels, trends and differentials in sex ratio at birth in India.
2. To examine the socio-economic, biological, demographic factors affecting the sex ratio at birth in India.

In India women development has carved out a prominent figure in the development planning right from the dawn of independence. But the concept of women development has been changing. The welfare-oriented approach adopted in the first plan continued till the end of the fourth five-year plan. During the fifth plan there was a shift from welfare to development approach. However, during the 6th plan (1980-85) a multi-disciplinary development approach emphasizing on women's health, education and employment was adopted. During the 7th plan, there was a paradigm shift of development approach to empowerment.

The makers of the Indian Constitution were fully aware of women discrimination and therefore, made adequate provisions to remove inequality between men and women. Article 15 of the Indian Constitution prohibits any discrimination on ground-

of sex, while Article 15(3) clarifies that this provision will not prevent the state for making any special provision for women. Article 42 of the Constitution envisages that the State shall make provision securing just and humane conditions of work and for maternity relief. Besides, Directive Principles of State Policy also urge that the State shall direct its policy towards securing an adequate means of livelihood for women and ensuring equal pay for equal work both men and women.

Apart from these the historic 73rd constitutional amendment, which introduced three-tier Panchayati Raj System and envisaged reservation of 1/3rd of Seats for women is also a significant endeavour to promote the status of women through their participation in politics. Again the formulation of the National Commission for Women is an encouraging step in this direction.

But despite all these constitutional safeguards and colossal investment on women development in India, women are lagging much behind than men, which can be visualized from the following analysis. It exhibits the role of women in different social activities.

Decline in Sex-ratio

India shares a distinctive feature of the South Asian and Chinese population. With regard to the sex ratio, we find a declining trend with a century-old deficit of females. This is largely attributed to women's lower status in Indian society which has contributed to their marginalization. Although the recent Indian census has brought favorable figures for the better half of the society, a rise of 6 more females per 1000 males than the 927 of previous census, but the fall in sex ratio of 0-6 population is continuing as well as intensifying.

Despite of our all efforts for women and child health care, the sex ratio in India favours the masculine population. Table 2.3 clearly indicates a declining sex ratio of females. Though, female foetus has been proved to be biologically stronger than the male foetus, and 108 females are born per 100 males, yet there is a sharp deterioration of sex ratio. This is due to loss of more females on account of insufficient attention and care given to them, and relatively high proportion of deaths among

females at the time of puberty, nutritional deficiency, poverty etc.

Table 2.3 : Sex Ratio in India

Year	Females per 1000 Males
1901	972
1911	964
1951	946
1971	936
1991	927
2001	933

“Census of India 2001” Provisional population totals”.

The census of India has revealed the stunning fact that sex ratio in India has further gone down sharply from 972 females per 1000 males in 1901 to 933 in 2001. The overall sex ratio has declined between 1971 and 1991 in all the major states of India, except, Kerala. The imbalance in the sex ratio has become more prominent in states like Rajasthan, Punjab, Haryana, Gujarat, and Maharashtra. Sex ratio at birth is one of the initial conditions which determines the sex ratio of the overall population. In a country like India which is undergoing through the demographic transition, sex ratio at birth in combination with the under enumeration of female births, or excess female mortality throughout the life course, have a potentially large effect on the overall sex ratio.

Sex ratio at birth has been measured as the ratio of male to female births. An examination of the birth registered in a wide variety of countries throughout the world shows that more male than female babies are born and that sex of the new born varies within a range of 104-107 male live births per 100 female live births. Among predominantly Negroid population, however, there exists tendency for the sex ratio at birth to be slightly lower around 102 to 103. It is widely believed that the primary sex ratio (sex ratio at conception) is much higher than the secondary sex ratio (sex ratio at birth). In the absence of any sex selective human interventions, an excess of male births

over female births ranging between 104 and 107 is well documented as a biological phenomena.

World-wide this differential shows very little regional variation. Biologically sex ratio is always in favour of males. A Statistical study of sex ratio at births registered in 75 territories with a relatively complete vital registration has confirmed the widely-held belief that the masculinity ratio at birth varies generally between 104 and 107. A few studies also suggested sex ratio at birth to be associated with the blood groups. The possibility of an association between the blood of the mother and the offspring and the sex of the children was suggested in studies of births in areas as different as Bombay, New York, London, and Baltimore. Other studies suggest that several other factors like race, season, and differences in climate, habits and customs of people also cited to influence the sex ratio at birth.

Some studies done on this field suggest that both timing and exposure to hormones; or to toxicants as well as materials appear to be determinant of the sex of the embryo. Occupational and environmental exposures also influence sex ratio at birth. Other researches held in western countries regarding this issue have hypothesized and tested that occupational exposure and workplace conditions, stress level of parents, older age of parents, coital frequency, in vitro fertilization, non-Hodkin Lymphoma, Hepatitis, and use of fertility drugs, such as clamiphene effect sex of the offspring. It is also believed that primary sex ratio is balancing the secondary sex ratio, as owing to higher biological vulnerability of male foetus 3-3.7 per cent more male foetal deaths take place over female foetal deaths.

Previous studies aimed to understand the proportion of male and female newborn suggest its relationship with the age of women, parity marital duration, parental age, sibship size, presence of dizygotic twins, and spontaneous abortions. Regarding the relationship of sex of the offspring and health conditions, studies show that the sex ratios of stillbirths decline as the proportions of stillbirths to live births decreases.

Moreover sex selective abortions almost certainly inflate the "natural" range of sex ratio at birth. This demographic

factor along with the combination of under enumeration of female births, or excess female mortality throughout the life course, has a potentially large effect on the over all sex ratios and it could increase the sex ratio of the country at large.

Data is taken from the two nationally representative sample surveys, National Family Health Survey I and II conducted in 1992-93 and 1998-99 respectively. Both surveys were designed on the lines of Demographic and Health Surveys (DHS) that have been conducted worldwide in many developing countries since the 1980s. Both these surveys include a household sample covering everyone in the sampled household, and an individual sample covering all ever-married women aged 13-49 in NFHS-I and 15-49 in NFHS-II within those households. NFHS-I covered 89771 women of 13-49, and NFHS-II covered 90303 ever-married women aged 15-49. Corresponding to these two samples are a household questionnaire and an individual questionnaire. In the case of household questionnaire, the household head or other knowledgeable adult in the household responded for the entire household.

In case of individual questionnaire, each ever-married woman responded for herself and her children. Both these surveys were designed to provide state-level estimates as well as national level estimates. Including a wide range of information on health and socio-demographic aspect, survey provides details on birth history, sex determination techniques, abortions, and son preference. To capture the contrasting demographic trends, and to understand this emerging issue in depth the study is done both at the national, and the state level, taking few selected states according to the range of their sex ratio at birth. The study deals with the state of Uttar Pradesh, Karnataka, and Punjab and country as a whole. The rational behind the selection of these states was their variation with the national value of sex ratio at birth which is 111 for SRS and 109 in NFHS-II. Punjab is having the value above than the national average (126 in SRS and 118 in NFHS-II); Karnataka is below the national value (106 in NFHS-II) and Uttar Pradesh falls in between the two (111 in NFHS-II) contributing the highest share in the population of India.

POLITICAL PARTICIPATION OF WOMEN

Truly speaking, the true spirit of democracy cannot be realized if marginalized sections that include women remain outside the ambit of the political system. Political participation does not mean only the right to vote but it includes the ability to influence policies and decision-making. But, unfortunately women are under-represented in all the wings of the Government—legislative, executive and judicial. In 1980 they constituted only 10 per cent of the World's parliamentarians and less than 4 per cent of the World's cabinet. In India as people's representatives, women have fared abysmally which can be visualized from Table 2.4.

Table 2.4 : Representation of Women in Lok Sabha

General Election	Year	Total No. of Seats	No. of Women Members	Percentage of the Total
First	1950	499	22	4.4
Second	1957	500	27	5.4
Third	1962	503	34	6.8
Fourth	1967	523	31	5.9
Fifth	1971	521	22	4.2
Sixth	1977	544	19	7.5
Seventh	1980	544	28	5.1
Eighth	1984	544	44	8.1
Ninth	1989	517	27	5.2
Tenth	1991	544	39	7.2
Eleventh	1996	544	40	7.4
Twelfth	1998	543	43	7.9

Table-2.4 reveals that women representation in the Lok Sabha have not increased significantly. Compared to representation of men, it is extremely low *i.e.* below 10 per cent always.

WOMEN LITERACY

Taking overall literacy rate in the developing countries of the World including India, it is found that women are on the whole less literate than men. In India in 1991 less than 40 per cent of women were literate. In Nepal the percentage of female literacy was 35 per cent, in Afghanistan it was 32 per cent and in Sudan it was 27 per cent. Thus, women constitute 2/3rd of the World's illiterates. The Table-2.5 indicates a comparative male-female literacy rate in India.

Table 2.5 : Literacy Rate in India

Census Year	Female	Male	Persons	Female-Male Gap in Literacy Rate
1961	12.98	34.44	24.02	21.49
1971	18.70	39.45	29.45	20.75
1981	20.76	56.38	43.57	26.62
1991	39.29	64.13	52.21	24.84
2001	54.16	75.16	65.38	21.69

Source: Census of India 2001 "Provisional Population totals".

Table 2.6 exhibits that female literacy is increasing gradually. But compared to male literacy, it is much low. Low weightage to girl students, their high dropout rate, poverty and present social system can be attributed for this.

Table 2.6 : Literacy Rates by Sex (1961-2001)

(in per cent)

Census Year	Females	Males	Persons	Male-Female Gap in Literacy Rate
1961	12.95	34.44	24.02	21.49
1971	18.70	39.45	29.45	20.75
1981	20.76	56.38	43.57	26.62
1991	39.29	64.13	52.21	24.84
2001	54.16	75.16	65.38	21.69

Source: Census of India, 2001.

Status of Women in India

41

The female literacy rate of our country has increased from 12.95 per cent in 1961 to 54.16 per cent in 2001. It means that female literacy grew at twice the rate than male literacy during the same period. The effects of formal education on Indian women over the so-called silent years between independence and the early 1970s was captured in the *Towards Equality Report* (GOI, 1974) which indicated its role in sharpening class inequalities between women. There has been an upsurge of consciousness throughout the country among families and girls on the need for education (Manjrekar, 2003).²¹

Again a close glance at Table-2.7 reveals that the female worker participation rate is much lower than that of male worker. But work participation rate among females is increasing gradually. The rate of increase is more pronounced in rural areas than in urban areas. This is simply because women get much scope of employment in the agriculture sector in the rural areas. The scope of women's participation in agriculture sector is vast. They perform a number of agricultural activities such as sowing, weeding, transplanting, harvesting, winnowing, threshing etc. But in almost all the states, they are discriminated with regard to wage employment. They do not own land. Most of them in rural areas are agricultural labourers. Besides agricultural activities women in rural areas are engaged in animal husbandry, weaving, tailoring, forestry, sericulture etc.

Table 2.7 : Women Work Participation Rates in India
(in per cent)

Census		Female	Male	Persons
1981	T	19.7	52.6	36.7
	R	23.1	53.8	38.8
	U	8.3	49.1	30.0
1991	T	22.3	51.6	37.5
	R	26.8	52.6	40.1
	U	9.3	48.9	30.2
2001	T	25.7	51.6	39.3
	R	31.0	52.4	42.0
	U	11.6	50.9	32.2

Further, women who are not in paid employment are also working quite much longer hours than men in performing household chores, such as cooking, fetching fuel and water, cleaning the house, utensils, looking after children and elderly persons etc. But surprisingly, their labour in performing, the above activities go un-noticed and un-rewarded.

A perusal of above analysis clearly shows the magnitude of discrimination and unequal treatment to women in India. The statistical facts and figures clearly depict the denial of "Social Justice" to women in a broad economic, political, social and judicial set-up.

The worrying problem of missing sex-ratio women to men- is falling abnormally. Now it stands as 933 females per 1000 males (2001 census). 108 girl children are born against 100 boy children in spite of girl child foeticides. But in the survival point women inequality begins at birth, with 109.5 male live births per 100 female live births (1991 census).

The literacy position also goes against ensuring justice to women in India. As per 2001 census the male literacy rate is 75.85 per cent and female is 54.16 per cent. Denial of education to girl child is more in comparison with male child. The dropout rate for girls is 68.38 per cent for classes' I-VII as against 59.38 per cent for boys (Ministry of HRD, Govt. of India, 1993). In the field of education, data show a disproportionate participation of women in various levels of education.

Primary Education—34.15 per cent, Middle Education—36.28 per cent, Secondary and Higher Secondary Education—33.15 per cent, Higher Education—below 15 per cent, Women representation in leading services also shows a dismal picture. Indian Administrative Service—9.9 per cent, Indian Police Service—2.21 per cent, Supreme Court Judge—1 out of 25 judges (1996), High Court Judges—3 per cent, Parliament Seats—49 (1999), State Legislatures—2 per cent to 8 per cent since independence, Chartered Accountants—5.8 per cent (1995), Registered Medical Practitioners—20.8 per cent, Women entrepreneurs—10 per cent. The latest data available so far reflect that women graduate seeking employments is 37.30 per cent (in rural areas) and 21 per cent (in urban areas) (S. Mag-2025

14.98 per cent of women in rural and 7.48 per cent of men in urban area.

Women are still deprived of participating in large numbers in Panchayati Raj institutions except their mandatory reservation of one-third seats. Grama Panchayata—40 per cent, Panchayata Samiti—33.75 per cent, Zilla Parisadas—32.28 per cent. Women's employment in Central Govt., main and quasi sectors, is 9.3 per cent and 12.7 per cent respectively. In State Govt.'s also the employment of women in quasi sector is 7.6 per cent. Merely 5.9 per cent of women are engaged in house-hold sectors as low paid workers or marginal workers (1991 census). The workforce participation for women in rural areas is estimated at 32.8 per cent and at 15.5 per cent in urban areas whereas the corresponding figures for men are higher (1994). As per 2001 census, the percentage of employment of women to total employment was as follows:

Agriculture—3.6 per cent, Industry—12.42 per cent, and Service—19.7 per cent. It is pertinent to mention that 70 per cent of female labour force in rural areas is illiterate as against 43.7 per cent of males. In urban areas the proportions are 40.5 per cent (males) and 17.9 per cent (females).

A sample survey conducted in 1991 reveals that only 13 per cent of women with landowning fathers have inherited land as daughters. In case of widows it is 49 per cent: still 51 per cent of widows are deprived to inherit land. On criminal grounds also women are becoming the innocent victims. The data available show that: Annually on an average police registers nearly 5000 cases of dowry death nearly 30000 cases of dowry harassments.

The number of cases of deserted women and divorce by mutual consent (often forced) is going up. It is estimated that more than 500000 cases of deserted women are pending in various courts for maintenance.

Nearly 12000 cases of rapes, 13000 cases of kidnapping, 26000 cases of molestation, and 11000 cases of sexual harassment are pending trial. Number of cases pending trial in courts on women crimes as on 1.1.98 is 43.96 lakhs. Non-

officially the numbers may be three times more than the actual figures.

The study revealed that sex ratio at birth has increased at the national level over the period of two consecutive surveys from 107 in NFHS-I to 109 in NFHS-II. At the state level, Assam, Rajasthan, Punjab, Haryana, and Uttar Pradesh have higher value of secondary sex ratio than the national level.

As for as the relationship of sex ratio at birth with socio-economic background is concerned, it is high in well off group, which is 109 with respect to 106 for low standard of living during the first survey and, 111 in comparison to 107 in the second survey at the national level. Similarly residence also makes positive impact on it as sex ratio at birth, as it is more masculine in case of urban residence.

In general at the state level, residence and standard of living are influencing sex ratio at birth, indicating the influence of availability of safe delivery systems and health care facilities on increasing masculinity among new born babies. In this way assuming that sex selective abortions are likely to be more in the families having high intensity of son preference, as well as accessibility to the technology the states, Punjab, Karnataka, and Uttar Pradesh can be placed in high, low and, moderate level of sex ratio at birth in almost all the socio-economic milieu.

Among the states, Karnataka shows the natural relation between sex ratio at birth and birth order. Opposite to that there is a large increase from first order to higher order births for Punjab, here; sex ratio at birth has increased from 110 to 125, 112 to 124 and 122 to 130 for 2nd, 3rd and 4th order from NFHS-I to NFHS-II. In case of Uttar Pradesh, the change in NFHS-II from NFHS-I is from 107 to 113, and 104 to 114 for 3rd and 4th order but no clear pattern has emerged within these surveys among the orders. Among these states Punjab is showing the highest fluctuation. The interpretation of this fluctuation may be accounted for high use of sex selective abortions. If sex selective abortion is occurring, one would expect it to be much less common to first order births, because as much as most couples consider sex selective abortion only when, they approach their desired family size without having attained their desired

number of sons and daughters that is why sex ratio at birth jumps surprisingly for higher order births in both the surveys.

INFANT MORTALITY RATIO (IMR)

Death rate in Orissa is one of the highest in India with 11 per 1000 population in comparison to national average of 8.9. This is also higher than all other states referred above. The age specific death rate shows that mortality of girls occur some where between the growing age and period of adolescent which is regarded as most important preparatory period of girls' life for motherhood. The IMR has been taken as one of the important measurement of health status of population and indicator of women's development in general. The less the number of infants die in a year, higher the status of women.

The IMR is sharply declined in Orissa since 1991, but the ratio is highest in Orissa among the states with 96 deaths per 1000 population. In 1997 it is higher about 35.21 per cent to the national death rate of 71. Up to 1995 the IMR in Orissa remained three digits with 103. But today the death rate still remains high with 100 in the rural areas of the state.

Life expectancy at birth is another measurement which indicates the general health of a population. The life expectancy at birth of females in Orissa remained at 58 years during the period of 1991-96 as against 60 years for the males during the same period. The all India figures of life expectancy at birth show a different trend; females live longer than males, in the former case it is 61 years while the latter live up to 60 years. According to the Census of India 1991, the mean age of women in Orissa at the time of marriage was 19.1 years.

LITERACY

There is a direct link between literacy and health. Irrespective of economic development, low rate of literacy, especially literacy of the females is one of the important causes of low health status of females. According to the recent census of 2001, the female literacy in Orissa is 50.97 per cent as against literacy of about 75.95 per cent among males. The combined general literacy of male and female together is 63.61 per cent in 2001.

There is a wide gap between male and female literacy in the state. Since independence the percentage of female literacy increased from 4.52 to 50.97 per cent, an increase of about 46.45 per cent over five decades, which forms about annual growth rate of about 0.93 per cent. In comparison to this the male literacy in the state increased from 27.32 to 75.95 per cent in 50 years, a net growth rate of about 48.63 per cent, which formed a higher rate of annual growth of literacy among the males to the extent of 0.97 per cent

There is a wide difference of literacy rate among females in the districts of Orissa. The district of Khordha registered highest per cent of female literacy of 71.06 per cent in comparison to the tribal district of Malkangiri with a lowest per cent of literacy rate of 21.02 per cent according to the census of 2001. The four tribal districts of Koraput, Rayagada, Malkangiri and Nabarangpur have 24.81, 24.31, 21.28 and 21.02 per cent of literacy rate respectively.

The growth of male and female literacy in Orissa from the year 1951 to 2001 is presented in Table 2.8.

Table 2.8 : Growth of Male and Female Literacy in Orissa 1951-2001

Year	Persons	Male	Female	Difference
1951	15.80	11.3	4.50	6.8
1961	21.66	34.68	8.65	26.03
1971	26.18	38.29	13.92	24.37
1981	34.23	47.10	21.92	25.98
1991	49.09	63.09	34.68	28.41
2001	63.61	75.95	50.97	24.98

Source: Census of India 2001.

LITERACY AND POVERTY

There is direct relationship between the rate of literacy and people below the poverty line in an area. The district figures of female literacy and the people below the poverty line in the districts show that there is high positive co-relation between the two. Districts with low literacy among the women

have high incidence of poverty. The district of Koraput with 24.41 per cent of female literacy has high incidence of poverty with 83.81 per cent of people below the poverty line. On the other hand Ganjam with high rate of female literacy of 47.70 has 55 per cent of people below the poverty line.

Percentages of female literacy and percentage of people below the poverty line in the 15 districts of Orissa is presented in Table 2.9.

Table 2.9 : Female Literacy and Poverty in the Districts

Figures in per cent

No.	District	Female Literacy 2001	People below Poverty 1997
1.	Nabarangpur	21.02	73.66
2.	Malkangiri	21.28	81.88
3.	Rayagada	24.30	72.02
4.	Koraput	24.81	83.81
5.	Nuapada	26.01	85.70
6.	Gajapati	28.91	61.38
7.	Kalahandi	29.56	62.71
8.	Kandhamal	36.19	78.12
9.	Mayurbhanj	38.29	78.42
10.	Bolangir	39.27	61.06
11.	Boudh	39.78	80.20
12.	Kendijhar	46.71	76.96
13.	Sonepur	47.28	73.02
14.	Deoghar	47.56	78.79
15.	Ganjam	47.70	55.0,0

Source : DSH, Orissa 1999.

STATUS OF FEMALE LITERACY IN INDIA

The literacy rate in the country has increased from 18.33 per cent in 1951 to 64.84 per cent as per 2001 census. The female literacy rate has also increased from 8.86 per cent in 1951 to 53.67 per cent in 2001. The female literacy rate during the period 1991-2001 increased by 14.38 per cent whereas male literacy rate rose by 11.13 per cent. Thus, the female literacy

rate actually increased by 3.25 per cent more as compared to the male literacy rate Table 2.10.

Table 2.10 : Female Differential during 1951-2001 in Literacy Rate

	Total	Males	Females	Differential
1951	18.33	27.16	8.86	18.30
1961	28.30	40.40	15.35	25.05
1971	34.45	45.95	21.97	23.98
1981	43.57	56.38	29.76	26.62
1991	52.21	64.13	39.29	24.84
2001	64.84	75.26	53.67	21.59

Source : Directorate of Adult Education, Ministry of Human Resources Development, Government of India, 2005.

Factors Responsible for Poor Female Literacy Rate

Historically, a variety of factors have been found to be responsible for poor female literacy rate, viz.,

- Gender based inequality,
- Social discrimination and economic exploitation,
- Occupation of girl child in domestic chores,
- Low enrolment of girls in schools.

Strategies Adopted by the Government for Improving Female Literacy

The main strategies adopted by the Government for improving female literacy and empowerment include:

- National Literacy Mission for imparting functional literacy
- Non-formal Education,
- Mahila Samakhya,
- Sarva Shiksha Abhiyan.

Impact of Literacy Programmes on Women's Empowerment

- Heightened social awareness
- Increased school enrolment
- Increase in self confidence and personality development
- Gender equity and women's empowerment
- Status in the family
- Educational equality
- Women as entrepreneurs
- Household savings and access to credit
- Health and hygiene.

Correlation between Literacy, Status of Women and Social Impact*

- Literate women take better care of their health during pregnancy. 91.2 per cent of literate women had taken tetanus toxide injection as compared to only 54.7 per cent illiterate women.
- 86.5 per cent educated women took folic acid tablets as compared to 43.6 per cent among illiterate women.
- Literate women are more aware of the benefits of small family and the practice of family planning.
- 76.4 per cent of literate women had heard or seen a media message on family planning as compared to 42.4 per cent of illiterate women.
- The fertility rate among illiterate women is 3.47 per cent as compared to 2.64 in literate women.
- 87 deaths per 1,000 live births for illiterate mothers as compared to 33 deaths per 1,000 live births for mothers who have completed high school.
- 73 per cent children of mothers who had completed high school were fully vaccinated (immunised) as compared to only 28 per cent of the children of the illiterate mothers.
- Only 18 per cent of illiterate women were aware of AIDS as compared to 54 per cent of literate women and 92 per cent of literate women who have compared high school.

Source : National Family Health Survey Report 1998-99.

Significant Impacts of Literacy Campaigns

- The literacy rates recorded an impressive increase of 12.63 percentage points from 52.21 in 1991 to 64.84 in 2001. This is the highest rate of increase in a decade since independence.
- The female literacy rate increased by 14.38 percentage points (from 39.29 to 53.67) as against 11.13 percentage points (64.13 to 75.26) in case of males during the same period.
- The gap in male-female literacy rate has decreased from 24.84 in 1991 to 21.59 percentage points in 2001.
- All state and union territories without exception have shown increase in literacy rates during 1991-2001.
- In all states and union territories except Bihar the male literacy is now over 60 per cent.
- Women have benefited significantly and the cause of women's equality has been promoted.
- Higher enrolment and retention of children in schools has been witnessed.
- Significantly enhanced participation in the family welfare programme has been noticed.
- Greater acceptance of the message of immunization has taken place with on improvement in its actual implementation.
- Social, cultural and linguistic integration and communal harmony have been promoted.
- Abominable social evils such as dowry, child marriage, beggary and alcoholism are being attacked.
- Grassroots level structures, such as Village Education Committees have been strengthened, giving rise to more effective social and community mobilization.
- Improved practices of domestic cleanliness have resulted in neo-literates showing a much higher desire to maintain a cleaner, germ-free household environment.
- Communities have been strengthened, have acquired a new cohesiveness and a capacity for group action.

Status of Women in India

51

- Communities have been provided the opportunity to plan, implement and evaluate their own programmes so that they may become empowered and self-reliant in their attempts to determine and sustain the course of their lives.

Table 2.11 : 23 Low Female Literacy Districts (India)

S. No.	District/ State	Literacy Rate 2001		
		Persons	Males	Females
1.	Shravasti (UP)	33.82	46.67	18.58
2.	Kishanganj (Bihar)	31.09	42.71	18.63
3.	Pakaur (Jharkhand)	30.65	40.23	20.61
4.	Nabarangapur (Orissa)	33.93	47.04	20.67
5.	Dantewada (Chhattisgarh)	30.17	39.75	20.75
6.	Supaul (Bihar)	37.28	52.42	20.81
7.	Malkangiri (Orissa)	30.53	40.14	20.91
8.	Balrampur (UP)	34.60	45.84	21.79
9.	Madhepura (Bihar)	36.07	48.80	22.11
10.	Araria (Bihar)	35.01	46.38	22.37
11.	Bahraich (UP)	35.16	45.58	22.78
12.	Garhwa (Jharkhand)	39.21	54.36	22.87
13.	Purnia (Bihar)	35.10	45.63	23.42
14.	Katihar (Bihar)	35.09	45.31	23.80
15.	Sheohar (Bihar)	35.27	45.28	23.86
16.	Koraput (Orissa)	35.72	17.20	24.26
17.	Purba Champaran (Bihar)	37.54	49.31	24.27
18.	Rayagada (Orissa)	36.15	48.18	24.56
19.	Badaun (UP)	38.17	48.96	25.14
20.	Paschim Champaran (Bihar)	38.93	51.08	25.23
21.	Saharsa (Bihar)	39.08	51.66	25.27
22.	Jhabua (Madhya Pradesh)	36.89	47.97	25.70
23.	Nuapada (Orissa)	42.00	58.46	25.79

EDUCATION AND STATUS OF WOMEN

Education is universally accepted as an instrument of improvement in the status of women. It is also considered as stepladder for occupational and social mobility. Post-independence period has witnessed a significant improvement in women's education in the state though the overall situation still remains far from satisfactory.

Enrolment of girls in primary schools marginally declined from 1990 to 1996 while comparing the four stages of Indian educational system that is primary, middle, secondary and college level. Enrolment of girls in the primary schools remained as low as nearly 17 per cent in comparison to the enrolment of boys throughout these years. The enrolment of girls during these years increased about 5 per cent in middle school level, 4 per cent in the high school level and three per cent in higher education.

Enrolment of boy and girl students in the educational institutions of the state from the primary school level to the college level education in terms of percent is presented in Table 2.12.

Table 2.12 : Women's Education in Orissa 1991-96

Figures in per cent

Year	Primary School		Secondary School		Middle School		Higher Education	
	Boy	Girl	Boy	Girl	Boy	Girl	Boy	Girl
1990-91	58.46	41.53	66.62	33.24	61.86	31.88	76.49	23.13
1991-92	58.45	41.54	66.45	33.54	61.91	38.08	76.36	23.27
1992-93	58.44	41.55	65.32	34.67	62.00	37.99	75.17	24.82
1993-94	58.44	41.45	64.91	35.08	62.02	37.97	70.91	28.78
1994-95	58.63	41.36	63.72	36.15	62.06	37.93	75.00	25.00
1995-96	58.63	41.36	63.38	36.61	61.96	38.03	74.77	25.00

Source : Statistical Abstract of Orissa. 1996-97.

Status of Women in India

53

In the middle level education, girls-boys ratio in enrolment is nearly 1 : 2. It was also same for the secondary level enrolment of both the sexes. In the higher education the gap of enrolment in boys and girls is still higher. The enrolment of girls is as fewer as one-third of boys. Comparing from primary to higher education the number of girls has been decreased consistently from 41.36 to 25 per cent during the period of 1991 to 1996.

Health and Nutrition Status of Women in States India

Table 2.13 : Anaemia among Women and Children (6-35 months), (in percentage), 2000

States	Anaemia among Ever Married Women (15-49 years)	Anaemia among Children (6-35 Months)
Andhra Pradesh	49.8	72.3
Arunachal Pradesh	62.5	54.5
Assam	69.7	63.2
Bihar	63.4	81.3
Delhi	40.5	69.0
Goa	36.4	53.4
Gujarat	46.3	74.5
Haryana	47.0	83.9
Himachal Pradesh	40.5	69.9
Jammu & Kashmir	58.7	71.1
Karnataka	42.4	70.6
Kerala	22.7	43.9
Madhya Pradesh	54.3	75.0
Maharashtra	48.5	76.0
Manipur	28.9	45.2

(contd...)

(contd...)

States	Anaemia among Ever Married Women (15-49 years)	Anaemia among Children (6-35 Months)
Meghalaya	63.3	67.6
Mizoram	48.0	57.2
Nagaland	38.4	43.7
Orissa	63.0	72.3
Punjab	41.4	80.0
Sikkim	61.1	76.5
Tamil Nadu	56.5	69.0
Tripura	N.A.	N.A.
Uttar Pradesh	48.7	73.9
West Bengal	62.7	78.3
India	51.8	74.3

Source : International Institute for Population Sciences, (2000). National Family Health Survey; 1998-99 (NFHS-II): Mumbai. pp. 252, 273.

Iodine Deficiency Disorder—Goitre

The prevalence of iodine deficiency disorder goitre was found to be quite high in Madhya Pradesh (5.74%), Mizoram (4.86%), Karnataka (4.11%), Kerala (4.05%), Manipur (3.83%), Himachal Pradesh (2.47%) and Sikkim (1.96 per cent), as reported by the DNP study and NNMB survey report.

Iron Deficiency Disorder—Anaemia

Anaemia among children (0-3 years) was found to be quite high, as reported by the National Family Health Survey 1998-99 (NFHS-II) be anaemic. The incidence of anaemia among girls and women aged 15-49 years was found to be around 52 per cent.

The incidence of anaemia among children aged 6-35 months, and girls and boys.

About 31 per cent women and 78 per cent children were covered under the prophylaxis programmes during 1998-99.

HEALTH STATUS

The Government of India with the goal of "Health for all" by the year 2000 started different health projects from the year 1980. Some of these health development projects are sponsored by various international organisation and agencies in addition to the projects financed by the Government of India as well as the Government of Orissa. But even after about two decades of implementation of different health projects the status of health in the state has not improved substantially.

Eight indicators can be taken for the measurement of the degree of health status of the population. The overall measures of health status for Orissa shows that it is far from satisfactory. These eight indicators for Orissa are presented in Table 2.14.

Table 2.14 : Indicators of Health Status of Orissa

No.	Indicator	Figure
1.	Sex Ratio (2001)	972
2.	Birth Rate (1996)	26.8
3.	Death Rate (1996)	10.7
4.	Female Literacy (2001)	50.97
5.	Infant Mortality Rate (1998) (Per 1000 live births)	96
6.	Total Fertility Rate (1993) (Per women)	3.1
7.	Mean Age at Marriage (1991)	19.1
8.	Female Life Expectancy (1996)	58

Source : Economic Survey of Orissa, 1997-98, and Census of India 2001

Based on a weight-for-height index, about 48 per cent of women in Orissa are undernourished. Nutritional deficits are particularly serious for women in rural areas and in disadvantaged socio-economic groups. Women who are undernourished themselves are also much more likely than

other women who have children who are undernourished. Anaemia is a serious problem among women in every population group, with prevalence rates ranging from 44 to 75 per cent. On an average about 65 per cent of women in Orissa have some degree of anaemia.

NUTRITION OF WOMEN

The nutritional status of women has not improved substantially and in some regions has deteriorated over the past few years faster than the nutrition of men. The per capita calorie intake in the country as a whole declined from 2445 in 1961 to 2179 in 1971. The worst sufferers are the women as agricultural labourers, living in slums and in the remote tribal areas. Malnutrition among women has further been aggravated due to repeated pregnancy and lactation. During pregnancy a woman requires about 2,500 calories of nutritious food but receives only about 1,440. Three main nutrients required for pregnant women are protein, iron and calcium. It is found that the pregnant women are not getting their required nutrients: the deficiencies are as high as 80 per cent in case of calcium followed by iron and proteins 55 and 33 per cent respectively.

The nutrients needed and provided to the pregnant women and the deficiencies thereof is presented in Table-2.15.

Table 2.15 : Nutrients Requirement for Pregnant Women

(Figures in Grams)

Food	Needed	Provided	Deficiency (Per cent)
Protein	55	37	32.72
Iron	40	18	55.00
Calcium	1	0.2	80.00

Source : The ICMR Report 1981.

FAMILY PLANNING

The rate of fertility is gradually in the declining trend in Orissa. Throughout their child-bearing period the fertility rate remained 2.9 in the year 1992-93 (NFHS-I) currently reduced

to 2.5. Efforts to encourage the trend towards lower fertility rate have to concentrate in those specific groups in the population whose fertility rate is higher than the state average.

It has been identified that in the following categories of women the rate of fertility is higher than other women. These categories are: rural women, illiterate women, poor women along with women of specific communities of Muslims, schedule castes and schedule tribes.

Fertility is more among the young women. It is found that about 16 per cent of the total fertility is from the females in the age group of 15-19 years. Studies confirm that health and mortality risks increase when women give birth at these young ages, both for the women themselves and for their children.

Modern women comparatively are more health conscious and prefer smaller families. About 5 per cent of the mothers reported that (NFHS-2) they preferred not to have child with in three year of their marriage, while about 12 per cent of mothers expressed that they would have preferred to delay the pregnancy. About 35 per cent of mothers who had three children and another 31 per cent of mothers with children four and more considered two-child norm is ideal for a family.

Orissan women who are not adopting family limitation measures are not, due to lack of knowledge, which is believed generally. About 98 per cent of the currently married women know at least one of the modern family planning methods. Women in Orissa familiar with female sterilisation which forms highest of about 98 per cent of all devise adopted for family planning. This is followed by male sterilisation of 90 per cent, oral pill by the women 75 per cent, Intrauterine devise by women 55 per cent and condom by men 53 per cent.

In 1992-93 about 36 per cent of women were using contraceptives but now the use increased to about 47 per cent. There is also urban-rural differences in use of contraceptives. About 54 per cent of urban families use contraceptives in one form or other but in the rural families it is lower to about 46 per cent.

Adoption of contraceptives increases with the increase of age of the women and also number of children in the family.

About 9 per cent of the newly wed women adopted contraceptive of temporary nature to delay the first birth of child. The use of contraceptives with Orissan women is highest—69 per cent in the age group of 40-44 years. The use of contraceptives is in second position 68 per cent—with the women having three children.

Hindu families prefer for a son that influences the use of contraceptives. Orissa is not an exception. About 9 per cent of the families with two children but without a son adopted male or female sterilisation, on the other hand about 18 per cent of the families adopted permanent sterilisation method to restrict their family.

The Government of India have been consistent in spreading the message of family planning measures from 1960 onwards. But now according to the National Family Health Survey, the family planning message reached the specific groups as stated in Table-2.16. It can be verified that out of six categories of under-privileged groups the reaching of message ranged from 28 to 63 per cent. The lowest percentage of social group women with 28 per cent is the scheduled tribe women. Other than these groups, that constitutes mainly higher income group people and the people other than scheduled and backward population, the message of family planning reached to the maximum of about 78 per cent.

Table 2.16 : Reception of Family Planning Message

No.	Social Group	Per cent
1	Illiterate Women	41
2	Lower Income Women	42
3	Schedule Cast Women	56
4	Schedule Tribe Women	28
5	Backward Class Women	63
6	Other Groups	78

Source : National Family Health Survey-II, 1999.

WORK PARTICIPATION

Due to some historical and social reasons women have lagged behind men relating to their productive participation in the society. They have mainly concentrated in the role of reproductive and service sectors whereas men have participated in productive activities and become the bread earners in the family. It has given men enough power to dictate over women both inside and outside the family. After fifty years of independence, even though there is no constitutional restrictions for women to participate in the remunerative jobs alike men, but due to some traditional social reasons they still remain inside the house doing only household chores instead of participating in the process of economic development.

As per 1991 census, about 20 per cent of females were working population in Orissa as against 80 per cent in case of males. Within these 20 per cent of female workers again 59 per cent are categorised as main workers and the rest of 41 per cent as marginal workers.

In the agricultural sector all the agricultural operations such as weeding, transplantation, threshing, harvesting of different crops, processing of paddy etc. are proximately done by women marginal workers. According to 1991 census, about 80.9 per cent of female workers were engaged in agriculture as marginal workers. Ploughing of land and other strenuous works done by men. But in this sector also, about 25.8 per cent of female workers were also engaged. About 55.1 per cent of the women workers were engaged as agricultural labours and play an important role in the development of Agriculture.

EMPLOYMENT IN ORGANISED SECTOR

Employment of women in the organised industrial sector in both private and public enterprises is very much limited. It may be observed from Table 2.17 that in both the sectors the participation of women workers is on increasing trend. In the year 1998 the total women workers engaged in the organised sector of Orissa remained about 11.49 per cent which does not reflect women's entry into the organised sector on a large scale.

Table 2.17 : Employment of Women in the Organised Sector of Orissa

(Figures in Per cent)

Year	Public Sector	Private Sector	Total
1990	8.23	12.04	8.77
1991	8.74	12.24	9.20
1992	8.78	12.73	9.30
1993	9.71	10.98	9.85
1994	10.03	12.42	10.32
1995	10.37	12.04	10.63
1996	9.43	13.40	9.87
1997	11.07	11.31	11.11
1998	11.54	11.12	11.49

Source : Economic Survey, Orissa 1998-99.

The State Government is giving high priority to provide jobs to women. As a result, the proportion of women employees in the organised sector has been gradually increasing. Orissa is one of the few pioneering States to reserve 30 per cent jobs for women in all the Government Departments and public undertakings. As on 31st March 2002, about 2.72 crore employees were engaged in the organised sector at all India level of which about 0.50 crore were female employees which constitute 18.1 per cent of the total employees engaged in the organised sector as against 17.9 per cent as on 31st March 2001. During the same period, 7.71 lakh employees were engaged in the organised sector in Orissa with 1.03 lakh female employees, which constitute 13.4 per cent of the total employees in the organised sector as against 12.7 per cent in the previous year. By the end of 2004 the employment in the organised public sector and private sector of the State was about 6.57 lakh and 0.89 lakh respectively. The percentage of women employees to the total employees in the public sector and in the organised private sector was 14.6 per cent and 11.36 per cent respectively. The women employees constituted 13.8 per cent of total employees in the organised sector at the end of 2003 which increased to 14.3 per cent by the end of 2004. Table-2.18 indicates the employment in the organized sector in the State since 2000.

Table 2.18 : Employment in the Organised Sector

(in thousands)

S. No.	Year	Public sector		Private sector		Total organised sector employment	Women employees in organised sector	Percentage of women employees to total employees
		Total	Women	Total	Women			
1.	2000	711	89	87	10	798	99	12.4
2.	2001	717	92	89	10	806	102	12.7
3.	2002	692	93	79	10	771	103	13.4
4.	2003	680	96	87	10	767	106	13.8
5.	2004	657	96	89	11	746	107	14.3

Source : Directorate of Employment, Orissa, Bhubaneswar.

In order to create greater employment avenues for women, both in organised as well as in un-organised sector, it has been proposed to continue the following measures during the Tenth Plan period:

- (i) To eliminate gender bias in recruitment and improve working condition for women employees.
- (ii) To organise women's associations in the form of societies to enable them to get part-time employment in the productive sectors.
- (iii) To keep a close watch on change of occupational structure of women workers and improve their educational standards.
- (iv) To explore new areas of employment for women.
- (v) To provide vocational training in various fields, to improve employable skills of educated as well as uneducated women.
- (vi) To develop new job opportunities and higher skill levels in the tertiary sector for educated women by providing training in specific fields.

EMPLOYMENT IN THE UNORGANISED SECTOR

A number of self employment and wage-employment schemes/programmes initiated during earlier Plans are continuing during the Tenth Plan period. The scheme "Swarnjayanti Gram Swarozgar Yojana" (SGSY) is being implemented in the State since 01.04.1999 by amalgamating the earlier schemes like I.R.D.P. (Integrated Rural Development Programme), TRYSEM (Training of Rural Youth for Self Employment) and DWCRA (Development of Women and Children in Rural Area). The objective of "SGSY" is to bring every assisted poor family above the poverty line in three years. 65,712 swarozgaries were assisted for self employment under this programme during 2004-05 with an expenditure of Rs. 82.82 crore as against 59,289 swarozgaries assisted with an expenditure of Rs. 66.99 crore during 2003-04. Out of 65,712 swarozgaries benefited during 2004-05, 16,243 belong to SC, 18,217 belong to ST and 55,952 were women beneficiaries.

The women workers are concentrating more in the private sector than in the public sector enterprises. It speaks availability of women as cheap labour to private employers. Women face more vulnerability at workplace in private sector than in public sector employment. However, it has been found that women's participation in public sector enterprises is gradually on increase from 8.23 per cent in 1990 to 11.54 per cent by the year 1998. On the other hand the employment of women is in the declining trend from 12.4 per cent to 11.12 per cent. In the terminal year of 1998 the participation of women in both the sectors almost remained same. This low level of employment of women in the organised sector of Orissa is mainly due to low level of educational status of women in the state. But the growth of female education coupled with social rethinking on gender relations may result in fundamental change in the pattern of power relations within families and outer world (Baral & Das, 1999).

PROBLEMS IN INFORMAL SECTOR

In the informal sector where majority of working women are engaged faced different health problems at their workplace. In the informal sector since the workers are not organised

they cannot raise their voice to provide certain facilities at the workplace. If they make any complaint they have to loose their work. In these circumstances the women workers in the informal sectors as well as the male workers were also used to the hazardous work and suffer from some ailments and diseases.

Two of the important problems faced by women in the unorganised sector are:

- (1) *Problem's related to the posture at work*: Women working in paper bag preparation, bidi workers, zari workers, lace makers, carpet makers etc. work even though the women work at their residences their bodies ache from continuously sitting in one position suffer particularly from pain in the back, shoulders and waist and stiffness in joints.
- (2) *Contact with hazardous materials*: Constant contact with wood smoke, cashew oil in cashew industries, and contact with carbon monoxide and some chemical fumes etc., fingers start burning and boils and abscesses appear on the hands. In mining, agriculture and construction work also there are numerous debilitating health hazards faced by the women workers.

The socio-economic indicators show that there is an increase in female literacy, work participation and a declining trend in their fertility. These indicators reveal that women are better placed in the society. More and more girls are attending school even in the rural areas. But the dropout rate indicates that they leave the school after attaining puberty, particularly in the rural areas. Quite often girls are married at a tender age; of course with modern methods of family planning there is some check in child birth. But these indicators have much less impact on enhancing the status of women in the family as well as in the society. There is still discrimination between a boy child and a girl child. Sharing of house work is still a taboo among boys. Cases of murder, physical and mental torture of women are increasing day by day. Even in well-to-do families the status of women has improved but little. Women are harassed in the workplace both in organised and unorganised sectors. The male/female dichotomy is a psychological trauma

afflicting the Orissan society. This is reflected in all the societal institutions.

REFERENCES

1. Tripathy, S.N. & Pradhan Premananda (2003), *Girl Child in India*, Discovery Publishing House, New Delhi.
2. Kapur, Pramila (1990), Nine point formula to remove the disabilities, *Kurukshetra*, September, p. 13.
3. Tripathy, S.N. (1989), *Bonded Labour in India*, Discovery Publishing House, New Delhi.
4. Burra, Neera (1995), *Born to work, child labour in India*, Oxford University Press, New Delhi.
5. Govt. of India (1992), *National Plan of Action for the SAARC Decade of the Girl Child (1990-2000)*, Department of Women and Child Development, New Delhi.
6. Gowariker, V. (1993), *The Inevitable Billion Plus*, Vichar Dhara Publication, Pune.
7. Jain, D and Chand, M. (1991), 'Rural Children at Work, Preliminary Results of a Pilot Study', *The Indian Journal of Social Work*, Vol. 40 (3), pp. 311-322.
8. Aparna, Subramaniam, (1991), Work Patterns of the Girl Child, *The Indian Journal of Social Work*, 52 (1), January, pp. 49-59.
9. Nayar, Usha (1991), Labour of the Indian Girl child: Multi Curse, Multi Abuse and Multi Neglect. *The Indian Journal of Social Work*, Vol. III. No. 1 January, pp. 37-47.
10. Nangia, Sudesh (1992), *Child Workers in the Carpet Weaving Industry of Jammu & Kashmir*, National Labour Institute, New Delhi.
11. Ghouse, A. (1992), *Street Children of Calcutta*, National Labour Institute, Noida.
12. Vijaya Kumar, S. (1992), Children of Darkness, *Man in India*, 72 (2) pp. 233-237.
13. Rao. B.V.R. and Mallik, B. (1992), *Street Children of Hyderabad*, National Labour Institute, Noida.
14. Panicker, Rita and Desai, Kalpana (1993), *Street Children of Delhi*, National Labour Institute, Noida.

15. Chandramowli, V. (1993), *There is Kingdom of God: "Jogin G.M. Child Labour Studies*, Sterling Publishing Pvt. Ltd., Bangalore.
16. Narayana, D.L. (1993), Perspectives of the Girl Child in the Third World in Bhagawan, P.D. Singh and Shukla Mohanty (Eds.), *Children At-Work, Problems and Policy Options*, B.R. Publishing, New Delhi.
17. Verma, Meera and Verma, Neeta (1993), Incidence of Female Child Labour in India, in Bhagawan, P.D. Singh and Shukla Mohanty (Eds.), *Children At-Work, Problems and Policy Options*, B.R. Publishing, New Delhi.
18. Chowdhry, Poul D. (1995) *Girl Child and Gender Bias*, Vol 25, 2 & 3, June-Sept, pp. 84-93.
19. Kiran, Devandra (1995) Girl Child in Rural India, *Social Change*, Vol. 25, 2 and 3, June-Sept, pp 189-196.
20. Tripathy, S. N. & Pradhan Premananda (2003), Girl Child in India, *Op. cit.*
21. Manjrekar, N (2003), "Contemporary Challenges to Women's Education, Towards an Elusive Goal?" *Economic and Political Weekly*, October.

3

SOCIO-ECONOMIC CONDITIONS OF WOMEN

This chapter examines the socio-economic conditions of women based on field exploration in Brahmapur town (Orissa). Highlighting a brief profile of study area the analysis depicts interesting features of women and their socio-economic position.

The city of Brahmapur, a primer city of Orissa has population of 2,89,724 according to the census of 2001 and has satellite extensions of about another two lakhs which are not yet included in the municipal area of the city. Established in 1856 Brahmapur is the oldest Municipal Council of the state. The sex ratio is 931 in the city. About 82.25 per cent are literates of which male literacy is 93.60 and female literacy is 70.32 per cent. Out of total urban population of 28.18 lakhs in the fifteen towns of the state the slum population is about 6.35 lakhs, which constitutes about 51.29 per cent of the total population. In Brahmapur town the slum population is 70.5 thousand which constitute about 24.34 per cent of Brahmapur city.

LOCATION OF THE SAMPLE COLONY

In the city a seemingly prosperous and advanced area of Bijipur from which a narrow dirt road winds its way to the collection of tumble-down huts leads towards Gosninuagam. This is known as Dimira Bauri Street composed of 80 households. The Bauri caste is a declared scheduled caste in Orissa. On the way to Bijipur one mud hut an incongruous looking sign board announces the presence of an Anganbadi centre run by the ICDS.

The sample slum families have total population of 599 which comes to an average 7.48 members per family. Of the total population 320 are males and 279 are females. The female population includes 24 widows. The population of widows shows that about 30 per cent of families have widows in their houses as an extra member dependent on the earnings of the family.

The sex ratio of the general population shows that it has a ratio of 920, that is, 920 females for every one thousand male population. The number of children in the sample households is 334 which come to 4.18 children per family, which is far from the norm of the government to limit it within two children. Among the children the sex ratio is very low which is as low as 835 females per 1000 males.

Population in the slum sample households and the sex ratio figures are presented in Table 3.1.

AGE OF RESPONDENTS

Total number of women interviewed for the study is 101, who are in the age group of 13 years to above 50 years. The highest 43.56 per cent of the respondents are in the age group of 20-29 years followed by 23.76 per cent of the age group of 13-19 years.

Table 3.1 : Population in Slum Colony

Population	Male	Female	Total	Sex Ratio
Adult	138	127	265	920
Children	182	152	334	835
Total	320	279	599	871

Source : Compiled by the author from field data.

Total 101 women were interviewed in the sample colony to know about their socio-economic status and type of health and Medicare facilities availed by them, from the age of 13 to 55. Frequency of respondents in different age groups are presented in Table 3.2

Table 3.2 : Distribution of Respondents by Age Group

Age Group	Frequency	Per cent
13-19	24	23.76
20-29	44	43.56
30-39	20	19.80
40-49	11	10.89
50+	2	1.99
Total	101	100

Source : Compiled by the author from field data.

MARITAL STATUS

Marriage is regarded as the most important religious and social function of Bauri community. Selection of partners for the sons as well as for the daughters of this community rests exclusively on the parent. Previously the girls were given in marriage at the tender age of 12 to 15 years. As a result the girls became mothers early. But now gradually the trend is changing. About 8.57 per cent of women interviewed got married between 15 to 19 years of age.

Among the respondents 88.12 per cent are married, out of this about 5.94 per cent are separated from their husbands and remain single with their parents while about 12.87 per cent are widowers. There are about 11.88 per cent unmarried females of the respondents. Marital status of the sample respondents with their percentage are presented in Table 3.3.

Table 3.3 : Marital Status of the Respondents

Status	Women No.	Per cent
Married	70	69.31
Separated	6	5.94
Widowed	13	12.87
Sub-total	89	88.12
Unmarried	12	11.88
Total	101	100

Source : Compiled by the author from field data.

Among the married women interviewed the highest percentage of the women are in the modal group of age between 20 to 29 years. This is followed by the 24.29 per cent in the age group of aged 30 to 39 years. This shows that about 78.58 per cent of the married women are in the age group of 20 years to 39 years, quite experienced ones to explain their status in the family and also in the society they live in and work. The age groups of married women are presented in Table 3.4.

Table 3.4 : Age of Married Women

Age Group	Frequency	Per cent	Cumulative Per cent
13-19	8	11.43	11.43
20-29	38	54.29	65.72
30-39	17	24.29	90.00
40-49	6	8.57	98.58
50 +	1	1.42	100.00
Total	70	100	

Source : Compiled by the author from field data.

LEVEL OF EDUCATION

The level of education is very poor among the women in the slum households. Education is an important characteristic for the attainment of affective reproductive behavior, use of contraceptives, to maintain the health of children and practice of hygienic methods; that is for the overall status of women.

Only one of the respondents got schooling up to high school level. About 8.91 per cent attended primary school and about 5.94 per cent reached up to middle school level. Literacy ratio of slum population in Brahmapur according to 2001 is 24.48 per cent. It is interesting to find that the literacy ratio is higher with females than the males, in case of males the literacy ratio is 23.73 per cent as against 25.52 per cent among females. In the sample figures of the study the rate of literacy is as low as 15.85.

THE NATURE OF HOUSING

Housing is an acute problem in the slums. The slum families somehow or other try to have a shelter to sleep at night and keep their minimum household goods. Some of them have their own house. But others stay in the rented houses often making payments of house rent daily or once in a week. As the slum dwellers are mostly daily wage earners it is generally difficult for them to make monthly payment of rent for the house.

Majority of the families, 83.75 per cent, stay in Kaccha Houses. There is no ventilation in the houses which makes the houses damp and suffocating. In rainy days the floor becomes muddy, as the flooring is made up soil plastered by cow dung paste. The environment around the house is a determining factor for the health of people who live in the houses.

There is no drainage system worth the name. Wherever it is, it is unsatisfactory to maintain health of the people living in the slum. Mosquitoes and other small insects which are dangerous for human health surround the houses in dirty ditches and holes increasing their tribe and spreading diseases among the people. The garbage accumulated is never removed from the place either by the people living in the place or by the Municipal Council of Brahmapur.

The Kaccha houses in which the walls are generally constructed in mud or in bamboo screen pasted with mud are one roomed houses. There is only one entrance to the room and without any windows or ventilators with a low ceiling thatched with straw. The room is a multipurpose room which is used as living, bed, and store as well as for cooking food for the family. Very often food is cooked outside the house in the narrow varanda or in the open place throughout the year except in the rainy days. In the rainy season the room is used as a kitchen.

In the entire sample study only two families have Pucca house forming about 2.5 per cent of the total households. Number and per cent of three types of houses lived by the slum families are presented in Table 3.5.

About 81.25 per cent of the households live in one-room houses with family while about 15 per cent of them have two-

Socio-Economic Conditions of Women

71

roomed houses mostly in semi-pucca houses. In the two room houses the additional room is mainly used for cooking food and storing of household commodities and occasionally also used as bed room in emergencies.

Table 3.5 : Nature of Housing in the Slum

Nature of House	Household No	Per cent
Kaccha	67	83.75
Semi-Pucca	11	13.75
Pucca	2	2.50
Total	80	100

Source : Compiled by the author from field data.

One-room, two rooms and more than two rooms houses in the slum colony in percentage figures are shown in Table 3.6.

Table 3.6 : Room Types in the Slum Houses

Room Type	Families No.	Per cent
Single Room	65	81.25
Double Room	12	15.00
More than two rooms	3	3.75
Total	80	100

Source : Compiled by the author from field data.

METHODS OF COOKING

Cooking is one of the main activities of a household. Food is cooked on mud-prepared hearths prepared by the housewife herself. Traditionally wood has been the fuel used for cooking food and preparation of Tiffin. One improvement is found that previously earthen pots were used for the purpose of cooking but now most of the cooking is done in aluminium pots. About 72.5 per cent of the households use fuel wood for cooking.

About 15 per cent of the households use charcoal and cow-dung in addition to wood. It is found that one household having the modern cooking devise of L.P.G. gas, which costs only 1.25

per cent of the total households under study. Even though kerosene is a costlier fuel for cooking, about 11.75 per cent of the households have the luxury of using kerosene stoves for cooking. Different types of fuel used by the slum dwellers in their houses are presented in Table 3.7.

Table 3.7 : Types of Fuel used for Cooking

Fuel	House	Per cent
Fire-Wood	58	72.5
Charcoal and Cow Dung Cake	12	15.0
Kerosene Oil	9	11.25
L.P.G. Gas	1	1.25
Total	80	100

Source : Compiled by the author from field data.

Drinking Water

Drinking water is a problem in the urban areas. In the slum area under study there are two water taps provided by the Municipal Council of Brahmapur from which 56 per cent of families take water for cooking and drinking. Some use the tap water to bath the children near the tap and women also take their bath there in the early hours of the day. The rest of the families use open well water from the nearby wells for cooking, drinking and bathing.

There are no closed toilet facilities even in the few pucca houses. All the family members of the colony use the open space nearby for the purpose of toilets. The houses are very close to each other and there is no road of worth mentioning and no drainage facilities. During the rainy season there is water logging and water enters into many houses and makes their life miserable.

Out of semi-pucca and pucca houses comprising of 16.25 per cent of the total households about 8.75 per cent have the luxury of electricity in their houses. The rest of them use

Socio-Economic Conditions of Women

73

kerosene lamps or traditional wick lamps at the time of cooking or taking evening meals

PATTERN OF INCOME

Out of total number of sample women of 101 about 9.90 per cent of women are not working to earn income, they mainly dependent on the male members of the family to maintain the family affairs. On an average each working women contributes about Rs. 1,104 monthly or Rs. 13,248 annually.

The pattern of income earned by women and their percentage is presented in Table 3.8.

About 68.38 per cent of women earn on an average Rs. 1100 monthly. About 15.84 per cent earn about Rs. 1350 per month. The women earn mainly from daily labour and contribute substantially to the family income in addition to their work in the family of cooking and child care. The women contribute to the family income to the tune of 30 to 40 per cent.

Table 3.8 : Pattern of Income Earning by the Women

Income Rs.	No.	Total Income	Per cent
Not Working	10	0	9.90
< 1000	6	500	5.94
1000-1200	69	1100	68.38
1200-1500	16	1350	15.84
	101	995	100

Source : Compiled by the author from field data.

PATTERN OF EXPENDITURE

Food is the primary need of the family. The Bauri community is non-vegetarians in dietary habit, but it is found that about a small percentage, about 1.25 per cent has adopted pure vegetarian diet in their family. About 75.18 per cent of the family income is spent on food items. The average monthly expenditure on food items indicates their pattern of dietary habits.

Expenditure on different items of food incurred monthly by the family is presented in Table 3.9.

Table 3.9 : Monthly Expenditure on Food Items

Food items	Quantity in Kg.	Per cent	Cost in Rs.	Per cent
Cereals	60	65.93	420	50.62
Pulses	3	3.29	50	6.02
Roots & tubers	15	16.65	150	18.07
Green vegetables	5	5.49	50	6.02
Milk & its Products	2	2.19	20	2.41
Sugar	1	1.05	20	2.41
Other vegetables	3	3.30	25	3.01
Edible Oil	1	1.05	50	6.02
Non-vegetarian items	1	1.05	45	5.42
Total	91	100	830	100

Source : Compiled by the author from field data.

In the monthly quantity intake of food items the cereals constitute about 65.93 per cent and the rest constitutes other food items and on an average the daily intake comes to about 3.03 kg. in which the cereals constitutes about 2 kg. In value terms expenditure on cereals constitutes about 50.62 per cent followed by expenditure on roots and bulbs, mainly potato and onion, constituted 18.07 per cent in the second position. Expenditure on pulses and edible oils form 6 per cent each, in the third position of expenditure.

WORK PATTERN

Most of the women covered under the study were engaged in unorganized sectors. They work under an insecure environment and their quality of life is extremely tenuous.

Average monthly income of the women was around Rs. 1104, where they were getting around 250 days of work in a year. It was observed that women were generally working at least 13 to 15 hours a day and a large amount of women's time;

resources are spent on household work, fetching water, collecting fuel, childcare and other work. Men generally worked 8 to 10 hours a day. Most of the women were dissatisfied and unhappy that compared to their contribution and working hours, the value of their work is considered most insignificant or negligible.

It was noticed that women generally used their own wage incomes for the family. Since women feel that they are responsible for running their households and caring for their families, they feel that their children should have a better living standard. Hence they usually spend most of their income to run the household. None of the women found to be saving and even if someone has ever saved anything, it was spent for the family needs. The household chores still remain their primary responsibility and their husbands are never helpful. However, the decision-making power is totally vested in men only. Men control the family incomes and all responsibilities for financial transactions are vested in men. On the other hand, a lot of money is being wasted on liquor, gambling etc. This has led to several problems like woman-battering, shortage of food, indebtedness etc.

The arduousness of the journey to and fro from the work places cannot be spared. In my study 54 ladies said they cover a distance of 7 to 10 kilometers. 31 ladies trek distance between 4 to 5 kms. To add to this there is the prodding and the harassment of the supervisors and employers. Tired and exhausted, they lead a life without meaning. Theirs is a protracted struggle for bare survival.

ISSUES ON WOMEN'S HEALTH

The status of women's health is an important indicator of their development and their position in the society. Therefore, this chapter focuses on the position of women's health status with the help of field studies in the slum regions of Brahmapur town (Orissa).

The people of the slum area or the women folk are not at all conscious about their health problems or keep the environment clean for a healthy life. Of course to some extent poverty of the households is responsible for this attitude but they can be persuaded to maintain their environment clean and maintain their health conditions with their reach. They are also not conscious to avail medical facilities provided by the government.

SOURCE OF MEDICAL TREATMENT

Even at the beginning of 21st century, women in the Bauri community residing in the slums of Brahmapur prefer indigenous medicine for all of their ailments instead of modern allopathic treatment. Out of the total respondents 61 were fall ill of which about 50.81 per cent of them went to the hospital run by the government, where treatment and medicine is provided free of cost. Rest of the women except of about 3.28 per cent, availed traditional home remedy or went to the *Gunia* (treatment by invoking the spirit).

Treatment by the local home remedy constitutes about 32.79 per cent followed by the 13.12 per cent by *Gunia*. It is found that the women of this community firmly believe in God and approach the Babas and temple Priests (faith healers),

especially in case of children's ailments, for immediate cure instead of visiting the nearby hospital.

Different source of medical treatment for all general ailments is presented in Table 4.1.

Table 4.1 : Source of Medical Treatment

Category of Treatment	Woman No.	Per cent
Govt. Hospital	31	50.81
Private Hospital	2	3.28
Faith Healer	8	13.12
Home remedy	20	32.79
Total	61	100

Source: Compiled by the author from field data.

About 50 per cent of women who fall ill in one ailment or other did not prefer to go to the Government hospital for treatment. When asked why they were not approaching the government doctors at the Health Centres and dispensaries they have stated different reasons but four of the important reasons are:

- (1) The illness was not regarded as serious to consult a doctor even though they have no perfect knowledge about the illness.
- (2) The medical facilities are available in a medical centre which is not nearby hence there is negligence to go to a doctor.
- (3) The treatment under a doctor was felt expensive and they were not able to arrange finance for the treatment.
- (4) Most of the women are working women and find no time to go to the hospital for treatment by losing one day's wages which is regarded important to them.
- (5) The faith healers visit the slum areas with herbal medicine.

It is found that highest 48.57 per cent of women had not availed the hospital treatment due to the financial difficulties

even though they were interested to go to a doctor for good treatment. In the second position about 28.57 per cent of women did not go to the doctor thinking it is not necessary to go to doctor for such small ailments. Finding time out of work to go to a doctor was the reason given by about 15.71 per cent of women why they have not gone to the doctor, as all of them are working women.

The reasons given by the women why they were not availing the government hospitals is presented in Table 4.2.

Table 4.2 : Reasons for not going to Govt. Hospitals

Reasons not seeking Treatment in Govt. Hospitals	Women No.	Per cent
Felt not serious	20	28.57
Far away from the house	5	7.15
Financial difficulties	34	48.57
Lack of time	11	15.71
Total	70	100

Source: Compiled by the author from field data.

Out of the women who availed the facilities provided at government hospitals and dispensaries, about 65 per cent of them felt that they go to the government centres because the medicine and treatment is provided free. About 10 per cent of women expressed that they go to the government centres as they are not aware of any other private centre caring for the women and children, while about 15 per cent of the women who availed the facilities provided by the government centre said no such facilities are available nearby, hence they go to the government hospital compulsorily.

POLLUTION OF THE ENVIRONMENT

The main cause of the general illness and diseases is due to the pollution of the environment in the colony. The people of this colony throw the waste materials and excreta on the small narrow road in front of the house which remains there

throughout the day and night until next morning polluting the environment. The Municipal scavengers collect the waste materials only in the early morning. Cleaning delayed for several days creating polluted atmosphere in the colony. The waste discharges and the night soil are collected in the open space in the back of the houses which is spread away by street dogs and stray pigs. There is no drainage system worth the name. The small kaccha drain is filled with dirty polluted water. This pollution of the environment is the main cause of several diseases.

PREVALENT OF DISEASES

Skin Diseases

Most of the womenfolk in the colony work in the construction industry and are exposed to excessive heat during hot summer Sun. Due to heavy work at high temperature, the women loose about 3-4 litres of body fluid per hour. The salt in the body content decreases, sweat increases with rising temperature. It may lead to sodium depletion, dehydration or combination of both. The heat exhaustion sometimes, makes the patient intense thirsty, weakness and breakdown of central nervous system. It leads to several skin diseases.

Scabies and Eczema

Scabies and Eczema are the two skin diseases are commonly found among the women. Scabies is an infectious disease caused by the itch mite. It spreads by contact. The symptoms accompanying many skin diseases include itching, pain, and running, sensation of crawling numbness, constriction and tension of the skin. Eczema is of two types itching and non-itching. These are caused by infection and chemical or physical allergy. It is found that about 38 per cent of the women are suffering from scabies in one form or other.

Leprosy

Leprosy is a chronic infectious disease. The common factors in its epidemiology are direct and indirect contact and low hygienic standards in the family. There is one patient severely

infected by leprosy and two others some symptoms have developed for leprosy. The one woman who is suffering from leprosy is almost outcaste and her family too suffers from social handicaps. About 3 per cent of the women in the colony are infected by this disease.

GASTRO-INTESTINAL DISEASES

Water-borne diseases are occurring in summer and beginning of the rainy season. Most of the women suffer from the water-borne diseases of dysentery and diarrhoea is caused by polluted and contaminated water used by the families in the colony.

Dysentery

Frequency of dysentery is very high among the women of the sample slum colony. The safe water facility is not adequate especially during the summer months the shortage of water very acute and the women fall pray into this disease. Flies around the house, breeding in the dirty ditches take active role in spreading this disease. Frequent passage of watery stool along with blood and mucus makes the patient weak and some time serious. About 12 per cent of the women have been frequently suffered from this disease.

Jaundice

Jaundice is a seasonal health disorder found in rainy season mainly due to contaminated water. It indicates the abnormal destruction of red blood corpuscles. Jaundice virus infection upsets the function of liver in the body. It is infected to about 2 per cent of the women in the colony.

Tuberculosis

It is a chronic disease of long duration. Prevalence of tuberculosis infection refers to persons who have evidence of having been infected by *M. tuberculosis* as evidence by a positive tuberculosis test. There are several reasons for the disease. Unhealthy conditions at workplace and illventilated and over-crowd houses are prone to this disease. The social habit of

smoking and chewing tobacco increases the chances of occurrence of this disease. Workers in the construction and stone crushing industry are prone to this disease because of inhale of stone dust and cement dust at the workplace. About seven per cent of women are suffering from tuberculosis in the colony.

Anaemia

Iron deficiency has been labelled as the commonest nutritional deficiency. It may be mentioned that for practical purpose nutritional anaemia may be regarded as iron deficiency anaemia. Anaemia is a general disease among the pregnant women in the slum. A patient with anaemia looks pale and has pale skins and mucous membrane. This paleness is easily observed in the nails, lips and the tongue. In this the patient loses appetite, energy, interest in work and shortness of breath on exhaustion, palpitation of heart and general weakness. This disease also results from deficiency in folic acid. Vitamin B₁₂ proteins in the daily diet. About 20 per cent of pregnant women are infected by anaemia.

Diabetes

Even though most of the women are poor and there is nutritional deficiency but sugar complaints are also found among the women. In case of abnormal carbohydrate metabolism when sugar glucose cannot enter the body cells, it remains in the blood which leads to the excretion of sugar in the urine. Typical symptoms of this disease are excessive urination, excessive thirst and loss of weight. About 3 per cent of women are found suffering from this disease.

Hypertension

Hypertension or high blood pressures occur due to several reasons. The most common ones are over eating, obesity and mental tension due to family matters or worries at the workplace. The common symptoms include headache, dizziness, fatigue and restlessness. But the poor women are not generally aware about the blood pressure and complain only about

headache or restlessness and never go for checkup of blood pressure at the hospital. They take some home remedies to suppress the headache. Blood checkups was not carried on to know the blood pressure but on enquiry of the symptoms about 5 per cent of the women are seems to be suffering from hypertension.

BACKACHE/OSTEOMALACIA

Deficiency of vitamin leads to osteomalacia in adults. It is one of the commonest metabolic bone disorders in women in the reproductive age group belonging to the proper socio-economic conditions and living style in the slum area. Majority of women complained chronic backache and general pain in the body of about 15 per cent.

HEADACHE

- (a) *Megrim Headache* : The megrim is a one sided headache. It is more prevalent among women and usually it begins in the early teens. The most common cause of megrim headache is dilation of arteries in the head. As soon as the arteries in the head begin to dilate they trigger the release of a chemical substance called serotonin, which increase sensitivity to pain.
- (b) *Tension Headache* : Although megrim is the most painful headache but tension headache is most common. This headache is the result of consciously or unconsciously manifested emotional conflict. When the emotional state is dominated by feelings of anxiety, hostility or need for affection changes in the size of the cranial blood vessels are produced causing spasm of the skeletal muscles of the head and neck, which is responsible for the headache.

RESPIRATORY DISEASES

Asthma

It is a disease characterised by frequent deficiency in breathing due to the narrowing of small bronchial tubes. It is a common disorder among the slum adults and more frequent

in the workers of unorganised sector. When an individual come in contact with dust, smoke and other particles in the air, there is an allergic reaction which leads to the narrowing of airways. The chest tightness and the asthma patient have a struggle for breath. Air have trouble entering the lungs, but more than trying to escape and result expiration is prolonged and accompanied by a strained wheezing sound. The attack may be participated by an infection.

Bronchitis

Bronchitis is common among the slum women during the period of cold weather. It starts after catching cold of irritant fumes by environmental atmospheric pollution, smoke, dust and also due to smoking. Women with asthma and bronchitis constitute about 4 per cent.

Malaria

The prevalent Malaria is mainly due to polluted environment around the houses of the colony with dirty drains. Malaria is a protozoa parasite of their genus of plasmodium and transmitted by mosquitoes. The illventilated and ill-lighted houses provide ideal indoor resting place for mosquitoes in the colony. About 12 per cent of women suffering from fever including Malaria of about 3 per cent.

Disease and percentage of women suffering from it is presented in Table 4.3.

TYPE OF WOMEN

According to the nature of pregnancy and childcare of the women they can be classified into three categories: (a) Normal women, (b) Expectant mothers and (c) Lactating mothers. In the total number of women investigated 25 per cent are lactating mothers, 22 per cent are in the stage of conception while the rest of about 54 per cent are in the normal category. About 48.93 per cent of the women who are either in the expectant or lactation stage are in the age group of 20 to 29. In this age group about 53.48 per cent of women are either pregnant or in care of infant children.

Table 4.3 : Diseases among the Slum Women

Category	Women	Per cent
Anaemia	20	19.80
Headache & other Pains	15	14.86
Gastroenteritis	3	2.97
Respiratory Problems	4	3.96
Hypertension	4	3.96
Tuberculosis	7	6.93
Leprosy	3	2.97
Skin Diseases	39	38.61
Malaria	3	2.97
Diabetes	3	2.97
	101	100

Source: Compiled by the author from field data.

Age and category-wise figures of the women under study is presented in Table 4.4

Table 4.4 : Categories of Women in the Slum Area

Age	Normal	Pregnant	Lactating	Total
13-19	15	5	4	24
20-29	20	11	13	44
30-39	9	5	6	20
40-49	8	1	2	11
50 +	2	0	0	2
Total	54	22	25	101

Source: Compiled by the author from field data.

DIETARY HABITS OF WOMEN

Malnutrition and dietary deficiency is prominently found in the early age mothers. Two of the important reasons for the malnutrition are:

1. *Early Marriage* : A good proportion of girls get married at the early age just after menarche or attaining the age of menarche even though they are not attained puberty. The child mothers are considered "high risk" as both maternal and infant mortality rates are comparatively higher among these mothers.
2. *Gap between children* : The women continuously in the process of pregnancy and lactation cycle which makes the women weak and susceptible to different ailments. Many women had the next child when the older child is just about one year of age.

Pregnant Woman

The dietary intake of a pregnant woman in the sample slum colony contained 2497 calories per day against the standard requirement of 2525 which constitutes 2225 for a normal women and an extra addition of 300 calories for a pregnant women. This shows that the actual intake of calories by the women is about 1.11 calories less than the standard diet. It is observed that the energy intake mainly comes from the intake of cereals, which forms about 65.47 per cent of the total calorie intake by a woman.

Lactating Woman

Among the lactating mothers the energy intake is higher but still below the standard diet per day, as the standard requirement is 2775 calories, that is, an additional requirement of 550 calories to the normal energy requirement of 2275. But these slum women take about 2740 calories about 35 calories less than the standard daily requirement. Here too the main energy comes from rice and wheat for about 65.87 per cent. The additional calories mainly came from the fats and oils taken by the lactating women where it was not there for the pregnant women.

Normal Woman

A normal woman requires 2225 calories daily for a standard diet, but the slum women are availing about 2066 calorie daily

which is about 7.15 per cent below the standard requirement. The normal women take less fat and sugar in comparison to the pregnant or lactating mothers. This shows that there is dietary deficiency among the general women in the colony. The ICDS supplies wheat, Dal and Jaggery to the pregnant and lactating mothers regularly to increase their energy intake. Every pregnant/lactating woman gets 80 gm of wheat, 40 gm of Dal and 28 gm of Jaggery daily to supplement their usual food intake hence in comparison to the normal women these pregnant and lactating women get extra energy.

The actual intake of energy and standard energy required for the different categories of women and also other protein contents are presented in Table 4.5.

In calorie intake there is deficiency of about 7.14 per cent in the diets of the normal women but the deficiency among the pregnant and lactating women also they are lower than the standard calorie intake but the deficiency is comparatively low of 1.11 and 1.26 per cent respectively of pregnant and lactating women.

Table 4.5 : Energy Content in Food Intake

Food Items	Normal women	Pregnant Women	Lactating Women
Food Gm.	792	963	1023
Calorie intake	2066	2497	2740
Standard Unit	2225	2525	2775
Protein Gr.	50.9	66.9	70.5
Standard Unit	50.0	65.0	75.0
Calcium Mg.	283	494.8	549.8
Standard Unit	400	1000	1000
Iron Mg.	20.02	31.21	33.71
Standard Unit	30	38	30

Source : Compiled by the author from field data.

In the protein intake normal and pregnant women take proteins more than standard units but in case of lactating women the deficiency of protein are to the extent of 6 per cent. In the intake of calcium all the three category of women have deficiency to the per cent of 29.65, 50.5 and 45 per cent respectively for the normal, pregnant and lactating women respectively.

Iron deficiency is found among both normal and pregnant women to the extent of 33 and 18.42 per cent respectively. But in case of lactating women the iron intake is more than the standard intake to the extent of about 12.36 per cent.

ANTHROPOMETRIC ANALYSIS

For every height of an individual a standard weight is associated to accept the individual as maintaining standard of health. The height and weight of the women in the sample area is presented in Table 4.6 along with the standard weight for each height in the different age groups of the sample women. These are the height and weight of the normal women which excludes the pregnant and lactating women who are generally more than the normal weight.

In three categories of age group of women 13-19, 20-29 and 30-39 the actual weight is less than the standard weight according to their height, but in the age group of 40-49 they are little overweight to the extent of 3.95 per cent.

USE OF CONTRACEPTIVES

About 12.85 per cent of the slum women adopted contraceptives in one form or other to prevent children. Of which, the highest of about 5.71 per cent adopted by the women in the age group of 16 to 25 years. The newly weds below the age of 15 are not used to any form of contraceptives to prevent early child. It is found that 51 out of 70 married women that are about 72.86 per cent are not aware of the different family planning devises available to prevent birth. Another 14.29 per cent of women know about the availability of different devises to prevent birth but did not use any.

Table 4.6 : Anthropometric Measurement of Normal Women

Age Group	Frequency of women	Mean Height in CM	Mean Weight in Kg. Sample standard	
13-19	15	146	38	38.6
20-29	20	153.5	43.5	45.3
30-39	9	155	45	48.8
40-49	8	152	48	46.1

Source: Compiled by the author from field data.

Women in the three age groups, who are using contraceptives to prevent birth or spacing between child births is presented in Table 4.7.

Table 4.7 : Use of Contraceptives by Slum Women

Age in Years	No.	Per cent
13-15	0	0
16-25	4	5.71
26-35	3	4.29
36-45	2	2.85
Total	9	12.85

Source: Compiled by the author from field data.

ANTENATAL CARE OF WOMEN

Antenatal care (ANC) refers to pregnancy related health-care provided by the doctors or health workers in the health centres or at home of the pregnant women. All women during the period of conception must receive some basic but professional antenatal care for safe motherhood. The ANC can contribute significantly to control maternal morbidity and mortality. It includes provision of correct dietary facilities and supply of iron and folic acid tablets to the pregnant women to maintain good health in addition to medical care.

Improved nutritional status coupled with improved antenatal care can help to reduce the incidence of low weight

babies and by thus reduce the peri-natal, neo-natal and infant mortality. It is found that about 54.28 per cent of women are not at all availing antenatal service at home, from the health care centres or doctors. Figures displayed in Table 4.8 shows that the ANT services from the health workers at home are very popular. About 30 per cent of the pregnant women availed ANT service from this source.

Table 4.8 : Antenatal Care during Pregnancy

Type of Care	No.	Per cent
By Health workers at Home	21	30.00
Doctor	6	8.57
Traditional attendants	5	7.14
No Service	38	54.29
Total	70	100

Source: Compiled by the author from field data.

The women still take advice during the antenatal period from the traditional old-woman and *Dhais* in the village on the matters of nutrition and also take herbal medicine provided by them. These *Dhais* provide health care measures to about 7.14 per cent of pregnant women. About 8.57 per cent of women are consulting doctors during their pregnancy.

When all the married women were asked about the reason for not availing antenatal health services from outside the home, very interesting revelations were provided. The highest number of married women of 30, about 42.86 per cent expressed that the antenatal care services are not necessary to get advice and medicines from outside the house. Apart from this about 10 per cent of mothers felt outside consultation for a pregnant woman is not regarded as custom in their community.

Finance is regarded as one of the main reasons for the women to go for outside consultation; this was stated by about 24.29 per cent of the married women. Most of them are not aware that almost all the medicines and other help are provided free by the government in the health centres. About 2.85 per cent of women expressed that they have no information about

such antenatal care facilities are available in the local health centres provided free by the government. Some about 11.43 per cent of them even though they were aware of the ANC facilities provided by the government they were unable to avail the opportunity because of lack of time to go to such health centres. About 8.57 per cent of the women did not give any reason for the availing of the outside help for ANC and remained indifferent.

Table 4.9 provides the break-up of reasons given by the women in the sample study along with percentage figures.

Table 4.9 : Reasons for not Seeking ANC Outside Home

Reasons	No.	Per cent
Felt unnecessary	30	42.86
Financial Constraints	17	24.29
Not customary	7	10.00
No knowledge of service	2	2.85
Lack of time	8	11.43
No response	6	8.57
Total	70	100

Source: Compiled by the author from field data.

NEONATAL CARE

Neonatal tetanus is most common when the delivery takes place in an unhygienic environment and non-sterilised instruments are used for the cutting of umbilical cord. According to the National Immunisation Scheduled a pregnant women should receive two doses of tetanus toxoid injections, first when she is sixteen weeks pregnant and second dose when the women carries for 20 weeks.

The slum women of the sample study even though majority of them aware of the neonatal care provided by the government,

is found that about 92.85 per cent of the women knew about the availability of the supplements for the neonatal care of the child but not availing the opportunity. About 57.14 per cent of women knew about the T.T. injection which is essential for the care of the children and the mother but about 54.28 per cent of them availed the facility. Similarly about 78.57 per cent of women knew very well about the utility of iron supplement for the mother but actually about 74.28 per cent of them availed the opportunity. It is found that the women are reluctant to go to the doctor for checkups as about 12.80 per cent of them turned out for checkups before the doctors.

Measures taken by the pregnant women during pregnancy are presented in Table 4.10.

Table 4.10 : Quality of ANC during Pregnancy

Characteristics	Beneficiaries	Per cent
Knowledge about ANC	65	92.85
Know about iron supplement	55	78.57
Iron supplement taken	52	74.28
Know about T.T. Injection	40	57.14
T.T. taken during pregnancy	38	54.28
Physical examination done	9	12.8

Source: Compiled by the author from Field data.

THE DELIVERY SYSTEM

There is no ritual or celebration conducted when the women became pregnant like other community. Work is carried on as usual; they have to perform all their daily chores till the time of labour pain before delivery. Deliveries normally take place in their natal homes, at least the first ones almost always do. Deliveries subsequent children may take place in the husband's home. The deliveries generally take place in a secluded back corner of the house. The untrained birth attendant or dhai is the one primarily responsible for the deliveries, others mainly women relatives support her during this period. Antenatal care is out of the purview of the Bauri community.

The dhai is summoned when the pains start. The woman continues to go about her chores until the contractions are a few minutes apart. Then applies oil on her hands and massages the women abdomen from back to front. They appeared to be quite cognizant of complications that can occur during labour pains. If labour is too prolonged then the dhai may decide to take the women to a referral centre for her own safety. The dhais mentioned that they have successfully managed breach deliveries. They could manoeuvre the position of the baby abdominally and deliver the body safely. The dhais were aware of their limitations. If pregnant women have some special problems, bleeding or pain, they are sent to the hospital. Women are very much concerned about infertility. They tie a sacred thread in hope of getting pregnant.

PLACE OF DELIVERY

First priority has to be given for the health of the mother for safe and clean delivery, which is lacking in the developing countries (WHO, 1994) most of the maternal deaths and much of the chronic morbidity resulting from child birth are due to the failure to get timely help during the complications at the time of delivery. It is essential that delivery be conducted under proper hygienic conditions with the assistance of a trained medical practitioner.

In the study area it is found that home delivery is still prevalent which constitutes about 80 per cent of the total child births. It is generally an older woman in the family or the mother-in-law acts as delivery nurse with no training of any nature but with her experience of child delivery of its own. Sometimes an older woman in the locality also comes to the rescue of the mother when there are no elder women in the family. The women fear to go to the hospitals for the delivery either due to the fear of high expenses or sticking to the traditional home delivery as safer than in the hospitals where number of deliveries takes place at the same place daily with the fear of "bad contact" there.

About 18 per cent of the deliveries took place in the nearby Government hospitals that are to some extent conscious about the health of the mother and the child and prefer modern

medicine to the traditional treatment during and after the delivery of the child. About 2 per cent of the mothers for better care during the delivery preferred to go to the hospital for safe delivery but could not do it due to different reasons.

At the time of the delivery, even though it is conducted at home the family took the assistance of the traditional birth attendants with certain minimum payment. On the other hand about 10 per cent of the mothers took assistance from the relatives to attend to the child 'birth and stay with them for some days taking the care of the mother and child. Doctors and the trained nurses delivered the children to the extent of about 20 per cent of the deliveries, but out of that about 2 per cent of them invited either trained nurses or doctors to home for the delivery in some complicated cases for treatment.

It is observed that low productivity, poor infrastructure facility, geographical and social marginalisation, ignorance and unhygienic ways of living contribute poor health condition of the women. The work load distribution and the quantum of work that falls upon women also contributes to their increased susceptibility to morbidity and exposure to sun and wind have some blotching effect on their charm and beauty.

A lady physician appointed by the Municipal Council of Brahmapur visits the colony to look after the health problems of the women of the colony. The doctor comes twice during a month for health checkup and examines the pregnant and lactating mothers. Apart from this an Anganbadi health worker visits the colony to collect statistics on mothers and children and reported to the ANM and the ICDS.

A perusal of aforesaid analysis clearly demonstrates that women are victimised by several diseases comparatively more than their male counterpart. The food intake is lower than males, the pressure of work burden is higher on women and the problem of health is more acute in case of women. Education and health awareness among the females can support to develop the health efficiency and strengthen the human resources of our country.

FINDINGS AND CONCLUSIONS

The summary findings at all chapters have been presented in this chapter with useful suggestions.

Analysis of status of women in the slum area of Bauri Street of Brahmapur town reveals many interesting findings. The life struggle and work hazards of the slum women are different from the women of the other areas in the normal urban households of the town. They are also different from women of rural households in work culture and attitude towards life.

Women play a vital role in the process of national development. Though, they constitute about 50 per cent of total population of the State, they wallowed for so many years in the mire of illiteracy, poverty, obscurantism and exploitation. Successive plan periods underlined the attempt to bring the women at par with men to play an equal, active and meaningful role in all spheres of national life. With gradual spread of education, healthcare and empowerment, the position of women has begun to change. Government have been playing a proactive role in ensuring adequate representation of women in different socio-economic and political areas.

FEMALE LITERACY

Female literacy rate in the State has consistently been lower than that of males. Though the female literacy rate in the State increased from 4.5 per cent in 1951 to 50.51 per cent in 2001, it is still lower than the national average of 54.16 per cent and also much lower than the male literacy rate of 75.35 per cent in the State. In rural areas, the female literacy rate is 46.66 per cent, which is lower than the State average. For

development of female education, educational institutions including Kanyashrams have been established exclusively for girls, particularly in low literacy tribal areas. Education for girls, from primary to postgraduate level, has been made free. ITIs and polytechnics exclusively for women have been opened to provide them professional training.

WOMEN IN WORKFORCE

As per the population census of 2001, only 31.34 per cent of the total workers in Orissa are women. The main and marginal, women workers constitute 35.41 per cent and 64.59 per cent respectively of the total women workers. The unorganized primary sector, which includes agriculture, animal husbandry, fishery, forestry, mining and quarrying, plantations and allied activities, absorbs as much as 74 per cent of the total women workers. Nearly 8.5 per cent of the women workers are engaged in household industries. Other sectors of the economy provide employment to 17.5 per cent of the female-workers. Women constitute an important segment of the labourforce. The unpaid economic activities of women and their contribution in the domestic sector remain unreported and go largely unrecognized.

EMPLOYMENT OF WOMEN IN AGRICULTURE AND ALLIED ACTIVITIES

Women workers participate actively in agriculture including farm operations like sowing, transplanting, weeding, hoeing and harvesting, whereas the majority of male workers attend to ploughing operations. The women are employed sporadically and seasonally often with lower wages in comparison with their male counterparts. Widespread illiteracy and lack of social mobility account for the concentration of women in agriculture. According to 2001 census, 74 per cent of the female workforce was engaged in agriculture, 20.1 per cent as cultivators and 53.9 per cent of agricultural labourers. A large number of women workers are also engaged in marginal occupations such as collection of fish, fire wood and cow dung, fetching drinking water, maintenance of kitchen gardens, tailoring, weaving and such other works in order to supplement domestic activities and the family income.

EMPLOYMENT IN ORGANISED SECTOR

The status of women employment in the organized sector is reflected in Table 5.1. The proportion of women employees in the organised sector shows an increasing trend. Out of 7.46 lakh employees in the organised sector during 2004, women employees accounted for 14.3 per cent as against 13.8 per cent during 2003.

During the last five years (2000-2004), the number of women employees in the public sector has increased from 89,015 to 96,297 showing an increase of 8.2 per cent.

On the other hand, the number of women employees in the private sector during 2000 was 10,002, which increased to 10,491 in 2004 showing an increase of 4.9 per cent. To increase the number of women in public services, one-third of the vacancies in the State Government Departments arising in a year in Group B, Group C and Group D services/posts to be filled-up by direct recruitment have been reserved for women candidates.

The Orissa Civil Services (Reservation of Vacancies for Women in Public Services) Rules 1993 have been framed and are now in force. It has been decided by Government that all posts of Anganwadi workers, Supervisors and CDPOs will be filled by women. This has opened new job opportunities 'or women at village level.

Table 5.1: Employment of Women in the Organised Sector in Orissa

Sl. Year No.	Central Government		State Government		Quasi Government		Local bodies	
	Total	Women	Total	Women	Total	Women	Total	Women
1. 2000	79770	3753	403896	66511	207659	14546	19346	4205
2. 2001	79390	3712	408505	71071	209977	12828	19289	4234
3. 2002	80230	3784	396174	73790	197013	11639	18964	4018
4. 2003	76546	3573	393982	76850	190973	11202	18687	4019
5. 2004	73365	3553	381563	77789	184540	10986	17635	3969

Findings and Conclusions

97

(Cont.)

Sl.Year No.	Total Public sector		Private sector		Total employment		% of women employ- ment to total
	Total	Women	Total	Women	Total	Women	
1. 2000	710671	89015	86916	10002	797587	99017	12.41
2. 2001	717161	91845	88778	9917	805939	101762	12.63
3. 2002	692381	93231	76354	9634	768735	102865	13.38
4. 2003	680188	95644	87245	10140	767433	105784	13.78
5. 2004	657126	96297	89284	10491	746410	106788	14.31

Source : Directorate of Employment, Orissa.

DEVELOPMENT OF WOMEN UNDER FIVE YEAR PLANS

Women development programmes during the First Plan period were mainly welfare oriented. The Central Social Welfare Board and the State Social Welfare Board implement various women and children welfare programmes through voluntary organizations. During the Second Plan period, women were organized into Mahila Mandals in rural areas for facilitating convergence of health, nutrition and welfare measures. The Third and Fourth Plans accorded high priority to women's education, to immunisation of pre-school children and supplementary diet for children and expectant and nursing mothers. In the Fifth Plan, there was a shift in emphasis from welfare orientation to a developmental approach with the objective of removal of poverty and attainment of self-reliance. The Sixth Plan took cognizance of the deprivations suffered by and discrimination, overt or covert, practiced against women. A multidisciplinary approach was adopted with thrust on health, education and socio-economic development. Non-formal education centres for girls and vocational training centres for development of skill of targetted women beneficiaries were set up. Women were assisted on priority basis through IRD, TRYSEM and DWCR programmes. Nutritional interventions for the benefit of pregnant and nursing mothers belonging to the weaker sections were accorded high priority under the ICDS programme. During the Seventh Plan period, some more

beneficiary oriented programmes were launched for raising the economic and social status of women. In the Eighth Plan, a shift was made from development to empowerment of women. The empowerment measures for women included the constitutional amendment for at least 30 per cent representation in all elected local self-government bodies such as Panchayati Raj Institutions and Municipalities, establishment of a National Commission for Women at the Centre and State Commissions for Women at the State level, and launching of Mahila Samrudhi Yojana (MSY) for sensitizing women at grassroot level in the rural areas. In the Ninth Plan, the key elements of the strategy for development of women in the State were to *Minimise gender bias and improve working conditions, accord high priority to increase female literacy with quality education, focus on reproductive health, organize women Self Help Groups and improve their skills through vocational training for economic rehabilitation.*

In the Tenth Plan, four more strategies as follows, have been added.

- (i) To improve the nutritional and health status of children below the age of six years.
- (ii) To reduce the incidence of infant and child mortality and malnutrition.
- (iii) To ensure that funds/benefits are earmarked for women in all women related sectors.
- (iv) To include an identifiable Women Component Plan in all sectoral programmes of development to ensure that the benefits reach the women.

PREVENTION OF DOWRY

The State Human Rights Protection Cell is monitoring the dowry related cases comprising dowry homicide, dowry suicide, and dowry torture and non-dowry torture cases of the State. The Dowry Prohibition Act was enacted by the State government in 1991. NGOs are being encouraged with financial assistance by the State Government to propagate and organise dowryless marriages, anti-dowry campaigns, seminars, workshops and

Findings and Conclusions

99

street theatres to create mass awareness. Besides, the State Government have also issued special instructions for initiation of disciplinary action against its employees involved in dowry offences. The Government have appointed the Sub-Divisional Magistrates as the Dowry Prohibition Officers to act against dowry offenders. The Government have also appointed Advisory Boards to assist the Dowry Prohibition Officers in related cases. A committee with a senior women officer as chairperson has been set up in the districts by the Collector to monitor the problems of sexual harassment of women at the workplace. Similarly, at the State level, the Government have set up a Complaint Committee in the Secretariat with a senior I.P.S. officer to look into complaints. During the year 2004, 2312 dowry related cases were registered as against 2,269 in 2003.

STATE COMMISSION FOR WOMEN

For protecting and safeguarding the rights of women the State Commission for Women was constituted in January, 1993 under the State Commission for "Women Act, 1993". The Commission looks into specific cases of complaint of violence, atrocities, harassment, denial of rights and exploitation of women and takes corrective action to restore their legitimate rights. Besides family disputes are also resolved or compromised through counselling. During the year 2004-05, the Commission received 2,853 complaints comprising of 135 dowry deaths, 697 dowry tortures, 64 rapes, 51 kidnapping, 45 suicides, 502 non-dowry torture and 1,359 other miscellaneous cases. 1,673 cases including cases registered in the previous years were disposed of during 2004-05.

ORISSA STATE SOCIAL WELFARE ADVISORY BOARD (OSSWAB)

The Orissa State Social Welfare Advisory Board was created in 1954 for implementing and monitoring different welfare schemes with grants provided by the Central Social Welfare Board. Since inception, the Board has been working in the far-flung areas of the State for the development of neglected and

IMPORTANT FINDINGS

Some of the important findings are as follows:

- In the sample colony the number of children per family is 4.18 which far from the norm of the government to limit the size to two per family. Among the children the sex ratio is as low as 835 females per 1000 male children.
- The child marriage which was prevalent among the low caste women earlier it is reduced now to some extent; but even then about 11 per cent of girls married before the legally prescribed age.
- The rate of literacy among the women is recorded as at 15.85 per cent; much lower to even the rate of literacy of slum women in the other part of city calculated at 25.52 per cent according to the Census of India 2001.
- The pattern of houses is in most unhygienic condition which is responsible for all types of ailments. About 84 per cent of families live in one-room, one-door single houses constructed with mud wall and straw thatched roofs.
- The food is cooked with fire wood or charcoal mixed with cow dung outside the house by about 87 per cent of women. A single household has been using LPG Gas for cooking.
- On an average the women earned about Rs. 995 per month contributing around 30 to 40 per cent of the total family income. The range of income earnings by the women remained from Rs. 500 to Rs. 1350. About 68 per cent of women contributed to the family income to the extent of Rs. 1100
- In expenditure on food rice constitute about 51 per cent of the total food expenditure followed by roots and tubers in the second position with about 18 per cent of the expenditure. The non-vegetarian items in food constitute only about 6 per cent of the monthly expenditure on food.
- Apart from the wage-labour outside the home, in comparison to men the women work more hours at home.

home engaging themselves in cooking food, fetching water, in cleaning the house and the clothes and caring for the children. They work on an average 7 hours in the house in comparison to men folk who work about two hours daily attending household work.

- It is found that even though the health condition of the women are far from satisfactory but about 50 per cent of them are not availing the facilities provided by the government hospitals nearby. About 45 per cent of the women try to treat the illness either with some home remedies or go to a temple for spiritual healer.
- Different types of skin diseases are very much prevalent among the women in about 39 per cent of the women suffer from this disease followed by anaemia with about 20 per cent in the second position. In this small colony two of the deadly diseases of tuberculosis and leprosy is together constitutes about 9 per cent of women.
- In the three categories of women, in the calorie intake in food the ordinary women have deficiency of about 8 per cent but in other two categories of women, that is, pregnant women and lactating women, the deficiency in calorie intake is marginal. It is to the extent of about 2 per cent less than the standard calories required daily for the women. There is deficiency of protein, calcium and iron among the pregnant women, out of this calcium deficiency in the food is highest to the extent of about 50 per cent.
- The women in the lower age groups from 13 to 39 years the body weight are below the standard weight in comparison to their heights, which indicates that they are not in standard health. In the higher age group of 40-49 there is over weight of about 5 per cent.
- About 13 per cent of the women have been using contraceptives to prevent birth in the family of which the young women in the age group of 16-25 years are maximum adaptors of the contraceptives.
- In spite of antenatal facilities provided by the Government in the hospitals of the city about 55 per

cent of women did not avail the services even though about 93 per cent of women knew very well about the importance of antenatal care. On enquiry about 43 per cent of them expressed that they felt no need to go a doctors for health check up.

- The delivery of child is still remained a home affair never seemed to changed much over the years. Even though all facilities are available in the city for child and mother care still about 80 per cent of families in the slum area preferred to deliver the child at home in most unhygienic condition which is responsible for higher infant mortality in Orissa.
- Due to paucity of time and economic condition the women are not able to avail modern health care facilities.

CONCLUSION

The socio-economic condition and the health status of families analysed in the micro-study reveals that the standard of living of lower caste families in general and women in particular are far from satisfactory in comparison to the civilised families in the other part of the city of Brahmapur.

RECOMMENDATIONS

The government of India with the help of Planning Commission continuously have been making efforts for the socio-economic upliftment of the lower strata of the community. Special scheme and projects have been formulated for the development of women in the last three decades. Presently there is no dearth of schemes, projects and programmes to empower the women in the society, politically and also make efforts to provide them economic security.

The time has now arrived to implement those schemes sincerely. Unless integrated and co-ordinated efforts are made sincerely by all the Government Departments assigned for development work, the development of the lower strata of the community in general or development of women in particular cannot be achieved.

Findings and Conclusions

103

Moreover, it has been observed that there are leakages of Government fund leading to misappropriation and corruption. As a result of which, the benefits of planning and development are not percolating at the grass-root level. So there should be strict enforcement of provisions and punishment to corrupt officials for steady empowerment of women in the society.

Lastly, in a male dominated social change in the attitude of people towards their female counterpart is highly indispensable for desired socio-economic changes.

BIBLIOGRAPHY

- Adams, M.R., and Moss, M.O., (1995) *Food Microbiology*, New Age International Ltd., New Delhi, p. 136.
- Baral, J., Das, U., and Das, S., (1999) "Power Equation in Family" in *Family in Transition, Power and Development*, Northern Book Centre, New Delhi.
- Belenky, M., Clinchy, B., Goldberger N., and Tarule J., (1986) *Women's Ways of Knowing*, New York, Basic Books.
- Belle, D.,(1990) "Poverty and Women's Mental Health", *American Psychologist*, Vol. 45, pp. 385-38.
- Browning, C., (1976), *Women's Highest fulfillment*, St. Paul, Allahabad.
- Chakravati, B.K., Slum Problem in India, Genesis and Possible Solution, in Roy, P. and S.D. Gupta (eds.), *Urbanization and Slums*, Har Anand Publications, New Delhi.
- Edwin, M.J., (1998), *Health Action*, Vol. II, No. 2, February.
- Fogel, Catherine Ingram, and Woods, Nancy Fugate (1995), *Women's Health Care*, Sage Publication, New Delhi.
- Fowler, John M. (1970), *Radiant Living*, Oriental Watchman Publishing House, Poona.
- Ganesh, Kamala (1982), *Kottai Pillaimar of Srivaikuntam*, A Socio-Historical Study, Bombay University Press.
- Goode, W. (1971), "Force and Violence In the Family", *Journal of Marriage and the Family*, Vol. 52, pp. 624-36.
- Grant James, P., *The State of World's Children*, UNICEF, Oxford University Press.
- Haberman, M.R., Woods N.F., and Packard N.J. (1990), "Demands of Chronic Illness : Reliability and Validity

Assessment of the demands of Illness Inventory", *Holistic Nursing Practices*, Vol. 5(1).

Meheta, Ashoke (1973), *India Today*, S. Chand & Co., New Delhi, p. 65.

Nakkeeran. N. (2003), "Women's Work, Status and Fertility Land. Caste and Gender in a South Indian Village", *Economic and Political Weekly*, Vol. 38, No. 37, p. 3931.

Omvedt, G., "Violence Against Women", *New Movements and New Theories*, New Delhi.

Panda, P.K., (1997) Female Headship, Poverty and Child Welfare: A Study of Rural Orissa. *Economic and Political Weekly*, October. 25, 1997, p. 81.

Padmanahan, K. and Sahayadoss, S. (1994) "Choice of Health Care Services, IEA. 76th Annual Conference, February 1994, p. 66.

Peter Adamson (1998) "Woman's Health in Man's World", *Health Action*, Feb, 1998, Vol. XI, No. 2 from The Progress of Nations.

Pillai, Gita (1995) *ICCW Journal*, New Delhi, July-Dec. 1995. Vol. III. No. 1 & 2. p. 25.

Primary Health Care: Report on the International Conference on the Primary Health Care, *Health For All*, Sl. 1, Alma Ata, USSR.

Ram, Lily Pitam, Telu (1981), *Environmental Health and Hygiene*, Vikas Publishing House, New Delhi.

Rao, Venkateswara P., "Improving Rural Health Scenario". *Kurukshetra*. August. Vol. XXXIX, No. II, pp. 36-38.

Reddy, K.N., Selvaraju, V. "Determinants of Health Status in India: An Empirical Verification", *IEA*. Vol. 76. pp. 31-34.

Richardson, H., (1987) "The Health Plight of Rural Women". *Women and Health*, 1987, Vol. 12 (3/4), pp. 41-54.

Rodin J. and Ickovics, J, "Women's Health: Review & Research Agenda as We Approach the 21st Century, *American Psychologist* Vol. 45 (9).

- Sai Fred T, and Janet Nassim, The Need for Reproductive Health Approach, *International Journal of Gynecology and Obstetrics*, Supplement 3.
- Sen Amartya, 'Women Technology and Sexual Division of Labour', *Unctad Review*, Vol. 6.
- Shiva Kumar, A.K., Health as Development, *Economic and Political Weekly*, April 17, 1993, p. 772.
- Singhai, Gulabchand (1991), *Environment Nutrition and Health Hazards in India*, Vohra Publishers and Distributors, Allahabad.
- Srilakshmi, B., (1993) *Dietetics*, New Age International (P) Ltd.
- Srinivasan, S., Health Care in Rural Areas, *Kurukshetra*, Vol XXVI, No. II.
- Stellman, J. (1987) "The Working Environment of the Working Poor: An Analysis based on Workers' Compensation Claims, Census Data and known risk factors". *Women and Health*, 1987, 12 (3/4), pp. 83-102.
- WHO. Report of the WHO Meeting on Women and Health. Peebles, Edinburgh, May 25-27, 1985 (34).
- WHO Report, 1978 (32).

Index

A

- AIDS, 12, 14
- Alma Ata Conference, 20
- ANC during pregnancy, 91
- Antenatal care during pregnancy, 89
- Anthropometric measurement of normal women, 88

B

- Beast, Anne, 26
- Brahmapur, 66
- Burden of Hardship, 11
- Burra, 30

C

- Child health care, 35
- Constitution, 35
- Constraints on resources, 4
- Contraceptives used by slum women, 88
- Convention on the Right of the Child, 7
- Crime against women, 13

D

- Data collection, 24
- Decline in sex ratio, 35
- Demographic and Health Surveys (DHS), 38
- Demographic features, 27

- Development of women under five year plans, 97
- DWCRA, 62

E

- Economic independence, 4
- Edwin, 2
- Employment in
 - organised sector, 59, 96
 - unorganised sector, 62
- Employment of women in agriculture and allied activities, 95
- Energy content, 86

F

- Family planning message, 58
- Family planning, 56
- Female literacy, 51, 94
- Findings, 100

G

- Gandhi (Mahatma), 26
- Gender gap, 4
- Girl child, 29

H

- Hazards of employment, 4
- Health care system, 20
- Health status, 55
- Hindu philosophy, 26
- Hingrai, 7

HIV, 14

Human Development index (HDI), 1

I

Indian constitution, 34

Infant Mortality Rate, 8

Infant mortality ratio, 45

International Year of the Child (1979),
30

Introduction, 1-25

abortions, 10

access to food and nutrition, 13

access to health care services, 9

family planning, 9-10

female foeticide, 7-8

– literacy, 8-9

gender discrimination, 6-7

infertility, 10

lack of power, 12

male responsibility, 12

maternal mortality rate, 8

mental health, 11

objectives of the study, 15-16

reproductive health problems, 10

scope of the study, 14-15

 sex determination and female
 foeticide, 12-13

sex ratio, 7

violence against women, 13-14

women and work, 11

Iodine deficiency disorder, 54

Iron deficiency disorder, 54

Issues of women health, 76-93

antenatal care of women, 88-90

anthropometric analysis, 87

delivery system, 91-92

dietary habits of women, 84-85

lactating woman, 85

normal woman, 85-87

pregnant woman, 85

diseases among the slum women,
84

gastro-intestinal diseases, 80

anaemia, 81

backache, 82

diabetes, 81

dysentery, 80

headache, 82

hypertension, 81-82

jaundice, 80

tuberculosis, 80-81

government hospitals, 78

neonatal care, 90-91

place of delivery, 92-93

pollution of the environment, 78-
79

prevalent of diseases, 79

leprosy, 79-80

scabies and eczema, 79

skin diseases, 79

respiratory diseases, 82

asthma, 82-83

bronchitis, 83

malaria, 83

source of medical treatment, 76-
78

type of women, 83-84

use of contraceptives, 87-88

K

Karnataka, 4

L

Literacy, 45

Literacy and poverty, 46

Index

109

M

- Malnutrition, 13
- Marginalisation of women, 3
- Methodology, 23
- MMR, 8

N

- NGOs, 23
- Nutrition of women, 56

O

- Orissa State social welfare advisory board, 99
- Orissan society, 26

P

- Parameters of women health, 5
- Political participation of women, 39
- Poverty, 5, 7
- Pregnant rape, 13
- Prevention of dowry, 98
- Principal duty of women, 20
- Problems in informal sector, 62
 - contact with hazardous materials, 63
 - problems related to the posture at work, 63
- Proximate determinants, 3

R

- Ranade, M.G., 26
- Recommendations, 102
- Representation of women in Lok Sabha, 39
- Reproductive Tract infections, 10
- Review of literature, 16, 30
 - Aparna, 31
 - Belenky, M., 17
 - Belle, D., 18

- Browning, C., 18
- Chandramouli, 32
- Chowdhry, 33
- Ghouse, 32
- Grant, 22
- Haberman, 21
- ILO study, 30
- Jain, 30
- Kamala, 17
- Kiran, 33
- Kumar Shiva, 17
- Kumar, Vijay, 32
- Macklin, 22
- Meera, 33
- Meheta, 17
- Nakkeeran, 19
- Narayana, 32
- Omvedt, 19
- Padmanavan, 19
- Panda, P.K., 17
- Park, 18
- Pillai, Gita., 22
- Rao, V.P., 18, 32
- Reddy, K.N., 18
- Richardson, H., 17-18
- Rita, 32
- Rodin, 21
- Sai, 21
- Sen, Amartya, 16-17
- Srinivasan, S., 18
- Stellman, J., 21
- Sudesh, 31
- Tripathy, 33
- Usha, 31

- Roles, 4
- Rural and urban sex ratio, 27

S

- Sample design, 24
- Saraswati, Dayananda, 26
- Seeking ANC outside home, 90
- Sex differential, 4
- Sex pre-selection technology, 8
- Sex ratio, 27, 28
 at birth, 36
 – conception, 36
 in India, 36
- Socio economic conditions of women,
 66-75
 age of respondents, 67-68
 drinking water, 72-73
 level of education, 69
 location of the sample colony,
 66-67
 marital status, 68-69
 methods of cooking, 71-72
 nature of housing, 70-71
 pattern of expenditure, 73-74
 pattern of income, 73
 slum colony, 67
 work pattern, 74-75
- Socio economic indicators, 63
- State Commission for Women, 99
- Status of female literacy in India, 47
 correlation between literacy,
 status of women and social
 impact, 49
 education and status of women,
 52-53
 empowerment, 49
- health and nutrition status of
 women in states India, 53-
 54
- impact of literacy programmes,
 49
- significant impacts of literacy
 campaigns, 50-51
- strategies, 48
- Status of women in India, 26-65
 problems of girl child, 29-30
- STDs, 12, 14
- Supreme Court, 7
- Swarnjayanti Gram Swarozgar Yojana
 (SGSY), 62

T

TRYSEM, 62

V

Vidyasagar, Chandra Iswar, 26

Violence against women, 13

W

Women education in Orissa, 52

Women health, 2

Women in workforce, 95

Women literacy, 40
 literacy position, 42
 – rate in India, 40
 – rates by sex, 40
 women work participation rates
 in India, 41

Work participation, 59

World Bank, 4

□□□

G.M.C.E.J



9584

G.M. College of Education
 Raipur, Bantalab
 Jammu.

Acc. No.

dated

Gandhi Memorial College Of Education Bantalab Jammu

Gandhi Memorial College Of Education, Bhubaneswar

Mr. Suman Kumar Patnaik (b. 1973) did his M.A. in Linguistics and M.Phil in women studies from Berhampur University (Orissa). A well-known researcher and women activist. Mr. Patnaik is actively engaged in research activities in the Women's Studies Research Centre, Berhampur University (Orissa) and pursuing his Ph.D. work. He has participated in the national and international conferences.

ISBN 81-8411-079-0



SONALI PUBLICATIONS

4228/1, Ansari Road, Darya Ganj

New Delhi-110002 (India)

Phone: 23266109

E-mail:sonalipub@yahoo.co.in

ISBN 81-8411-079-0



9 788184 1110